# MIDTERM EVALUATION OF THE PRIVATE SECTOR POPULATION III PROJECT IN HONDURAS

POPTECH Report No. 98-142-072
September 1998

by

Jack Reynolds

Prepared for

U.S. Agency for International Development
Bureau for Global Programs
Office of Population
Contract No. CCP-3024-Q-00-3012
Project No. 936-3024

Edited and Produced by

Population Technical Assistance Project
1611 North Kent Street, Suite 508
Arlington, VA 22209 USA
Phone: 703/247-8630
Fax: 703/247-8640
E-mail: poptech@bhm.com

The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

# CONTENTS

APPENDICES

## ACKNOWLEDGMENTS

The author thanks the central and field staff of ASHONPLAFA for their openness, assistance, and support. The author also gives special thanks to Juanita Martinez, Germán Cerrato, Suyapa Pavón, and Daisy Cruz for their patience in answering his many requests for more information and data. They all made the author's job much easier.

# ABBREVIATIONS

| | |
|---|---|
| ARR | Annual Results Review |
| ASCH | Save the Children Association, Honduras |
| ASHONPLAFA | Honduran Family Planning Association |
| CESAMO | Medical Health Center |
| CESAR | Rural Health Center |
| CPR | Contraceptive prevalence rate |
| CSP | Community Services Program |
| CYP | Couple-years of protection |
| DIEP | Research, Evaluation, and Planning Division |
| DINCO | Information and Communications Division |
| EFHS | Epidemiology and Family Health Survey |
| FPMD | Family Planning Management Development project |
| IHSS | Honduran Social Security Institute |
| IPPF | International Planned Parenthood Federation |
| IR | Intermediate Result |
| IUD | Intrauterine device |
| KAP | Knowledge, attitudes, and practices |
| MANDOFER | Local pharmaceutical company |
| MIHC | Maternal-Infant Health Clinic |
| MIS | Management information system |
| MOH | Ministry of Health |
| MSP | Medical/Clinical Services Program |
| NGO | Non-governmental organization |
| PAHO | Pan American Health Organization |
| PASMO | Pan American Social Marketing Organization |
| PLAN | Foster Parents Plan International |
| POPTECH | Population Technical Assistance project |
| PRODIM | Programs for the Development of Infants and Women |
| PSP III | Private Sector Population III Project |
| PVO | Private Voluntary Organization |
| QA | Quality assurance |
| ROI | Return on investment |
| SAC | Clinic administration system |
| SCC | Cost control system |
| SCI | Inventory control system |
| SDP | Service delivery point |
| SIES | Integrated Service Statistics System |
| SMP | Social Marketing Program |
| SO | Strategic Objective |
| SOMARC | Social Marketing for Change project |

| | |
|---|---|
| SOW | Scope of work |
| TA | Technical assistance |
| TFR | Total fertility rate |
| UNFPA | United Nations Population Fund |
| USAID | U. S. Agency for International Development |
| VS | Voluntary sterilization |

# EXECUTIVE SUMMARY

## Introduction

The Private Sector Population III Project (PSP III), which is implemented by the Honduran Family Planning Association (ASHONPLAFA), was started in September 1995, and is scheduled to end in December 2000. This midterm evaluation of the project[1] attempts to answer a series of questions posed in the Scope of Work (SOW) that focus on its dual objectives of self-financing and contraceptive prevalence. By the end of 2000, ASHONPLAFA is expected to increase its self-financing to 63 percent of its total costs, and contraceptive prevalence in the country is expected to reach 54.6 percent.

ASHONPLAFA has six regional offices, each of which has a medical clinic that offers a variety of reproductive health services; seven satellite clinics that provide family planning services; a community services outreach program that sells condoms and pills through 1,600 posts and also promotes clinical services; and a Social Marketing Program that markets branded condoms and pills.

The evaluation was conducted over a six-week period in May and June 1998; the same time an evaluation of the Health Sector II Project was undertaken.

## Program Achievements

The two charts on the following page summarize ASHONPLAFA's achievements, including a projection for 1998. Since contraceptive prevalence cannot be measured every year, the couple-years of protection (CYP) index is used as a proxy in the interim years.

ASHONPLAFA is doing very well in terms of self-financing; chances are good that it will exceed the project goal in 1998. However, it is not doing well in CYP achievement. The total number of CYPs declined in 1996 and 1997, but thanks to the recent success of the Social Marketing Program, it should increase in 1998. Nevertheless, the total number of CYPs will still be only 64 percent of the original objective and 83 percent of the revised objective. This shortfall is not due to outside competition or a lack of demand. It is due to two incompatible objectives: cost-cutting strategies designed to increase self-financing and the need to increase CYPs.

ASHONPLAFA has also done very well with respect to benchmark achievement. The November 1997 Annual Results Review (ARR) showed that 37.5 of the 46 benchmarks were

[1] POPTECH conducted this evaluation based on a request and funding from USAID/Honduras.

# Self-Sufficiency and CYP Achievement at ASHONPLAFA, 1995-1998

Chart 1 Financial Self-Sufficiency, 1995-1998*

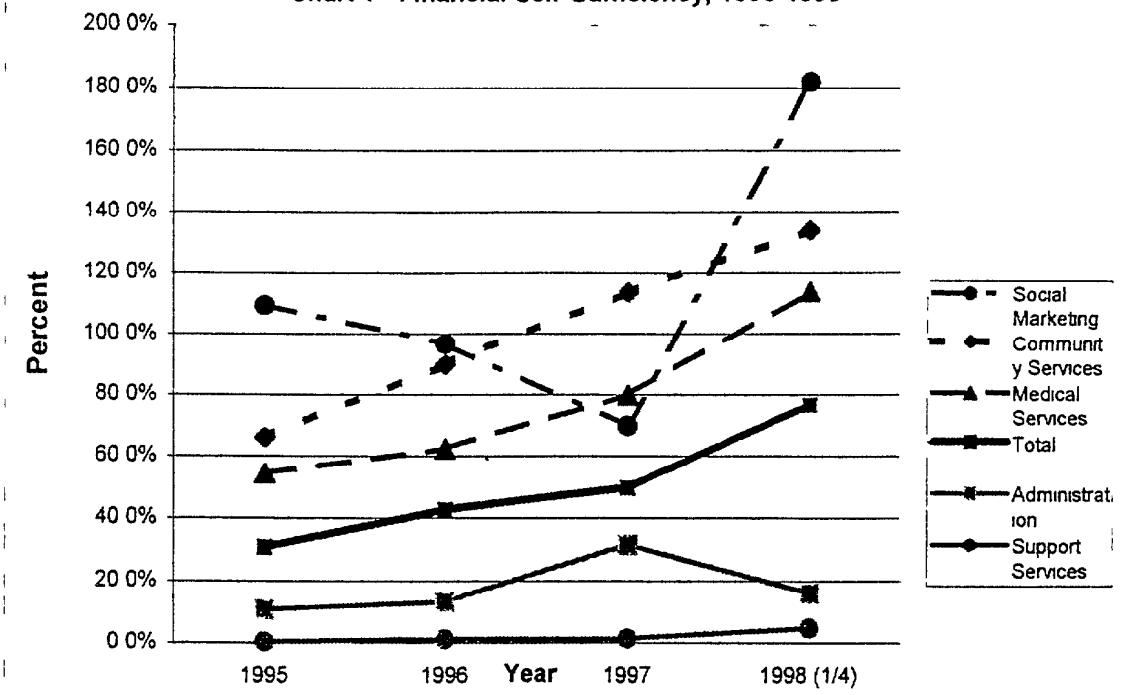
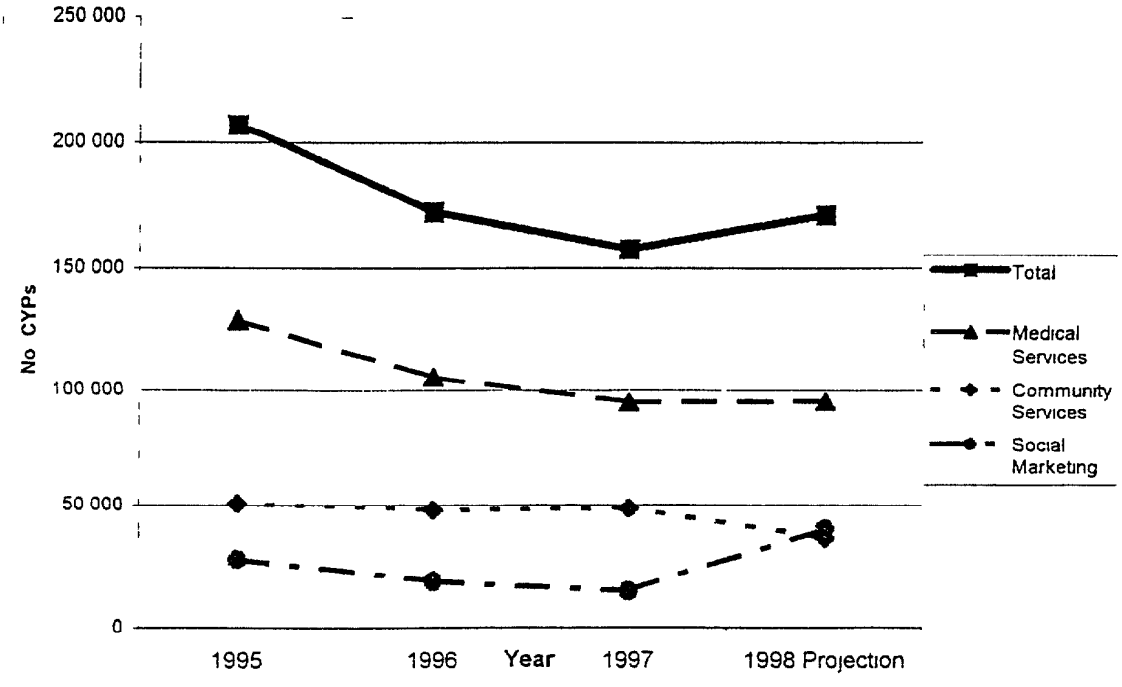



Chart 2 CYP Achievement 1995-1998



met or exceeded. Of the 8.5 that were not met, all but two have since been met. Thus, although ASHONPLAFA is performing very well in many respects, it is not able to increase self-financing and extend family planning services at the same time. The principal gap that is not being filled is the expansion of services in rural areas.

**Sustainability**

ASHONPLAFA reached 50 percent self-financing at the end of 1997. The first quarter figures for 1998 show that it is now at 76 percent self-financing. That percentage may drop over the year because some major expenditures are anticipated. However, this increase is still a remarkable achievement. Several factors account for this improvement: new leadership and a new corporate culture that embraces a business approach to its operations, an amazing surge in social marketing sales that is likely to be sustained, the addition of "diversified services" designed to attract middle-class clients, an increase in prices for services, reductions in costs in every way possible without affecting quality, and staff reductions at all levels.

ASHONPLAFA's managerial staff—at all levels—continue to look for additional ways to reduce costs and increase revenues. There is every reason to expect that they will continue to be successful. There is a problem, however, in that project emphasis is placed on self-financing rather than on sustainability of services or contraceptive prevalence. This input orientation should be overlaid with an outcome orientation that guides decisions regarding costs and revenues.

**CYP Achievement**

CYP achievement declined 17 percent in 1996 and another 9 percent in 1997. So far in 1998 it is up 9 percent. The recovery is largely because of the Social Marketing Program (SMP), which is projected to reach 40,000 CYPs this year, an increase of 175 percent over 1997. Such an increase will move SMP ahead of the Community Services Program (CSP) to second place with regard to CYP achievement. The major producer of CYPs is still the Medical/Clinical Service Program (MSP). It has also accounted for most of the decline in CYPs since 1995. The reason for this is the decline in voluntary sterilizations (VS) and IUD insertions, both medical/clinical procedures. In 1995, these two methods accounted for 128,000 CYPs; in 1997, they accounted for only 93,000. That is 97 percent of the difference in CYPs between these years.

Three factors seem to account for this decline: (1) increase in price, (2) reductions in promotion, and (3) reductions in transportation of women from rural areas to clinics. The first factor reduced demand. The latter two factors, which each reduced supply, contributed to improvements in self-financing, but the consequence has been a reduction in CYPs. If CYPs are to increase, something has to be done to make VS and IUDs more accessible and affordable to the poor, the uneducated, and the women in rural areas where unmet need is greatest. ASHONPLAFA cannot afford to do this. If they try, they will jeopardize their self-financing objectives.

## Support Systems and Other Issues

The evaluation team was asked to examine several other issues, including the management information system and the research and evaluation studies.

The management information system and the research and evaluation studies were found to be excellent. All have been improved greatly and are in demand because the new corporate culture places a high premium on using data for decision making.

The opportunity for ASHONPLAFA to become a distributor of the USAID regional Pan American Social Marketing Organization (PASMO) project's VIVE condom for HIV/AIDS prevention is a significant threat to ASHONPLAFA's general sustainability and its plans to cross-subsidize essential rural family planning services. The evaluation team strongly discourages this action.

## Lessons Learned

Eight generalizations emerge from this evaluation:

1. "Financial self-sufficiency" and increases in "CYP achievement" are mutually incompatible objectives.

2. If the objective is to affect inputs, then outcomes will be of secondary concern.

3. Diversification of services will increase income but not necessarily contraceptive prevalence (or CYPs).

4. Middle-class clients can be attracted to family planning clinics.

5. Competing political objectives among donors can damage a program.

6. When managers are seen to make decisions based on data and reason, then staff demand for and use of data will increase.

7. Economic incentives can be effective motivators, even in nonprofit organizations.

8. Reducing costs is not as important as increasing profits.

**Future Directions**

If a follow-on project is developed—and the team believes one is justified—then the funding mechanism should be designed to allow ASHONPLAFA as much independence as possible. The association needs to learn how to make its own decisions, to take responsibility for its actions, and to take care of itself. USAID can now reduce its involvement in day-to-day management by reducing benchmarks to a minimum, limiting reporting, and minimizing concurrence requirements.

The team would also like to suggest that ASHONPLAFA be relieved of its rural responsibilities so that it can concentrate on its urban clinics and Social Marketing Program. It has a good chance of becoming completely self-sufficient if this strategy is adopted.

A special rural project needs to be developed. Chapter 7 describes a strategy for building a complementary partnership of ASHONPLAFA's Community Services Program (perhaps started as a separate project or association), the newly funded private voluntary organizations (PVO), and the MOH Maternal-Infant Health Centers. By combining resources and selecting sites that represent significant unmet demand and have a high potential for success, USAID can make a significant contribution to increasing contraceptive prevalence in rural Honduras.

# RECOMMENDATIONS

## Sustainability

1. If decentralization of authority is an accepted goal, then ASHONPLAFA should take specific steps to shift authority for such functions as planning, budgeting, personnel, purchasing, and monitoring to the regions.

2. The USAID-ASHONPLAFA agreement should allow more latitude for ASHONPLAFA to plan and operate its own program, focusing more on achievement of outcomes and less on detailed inputs and activities.

3. ASHONPLAFA should undertake a management development program for all senior managers, including the regional chiefs, in addition to the regular training opportunities planned.

4. ASHONPLAFA should develop a master staffing plan that specifies the number and type of personnel to be employed at the clinic, regional, and central levels, and the most efficient mechanisms for doing so.

5. ASHONPLAFA should emphasize cost reductions at the central level and revenue generation at the program level. Clinics and community services should be encouraged and assisted to increase client load.

6. ASHONPLAFA should continue to expand its reproductive health services to as many clinics as possible. Maternity care, or low-tech, simple birthing centers, should be seriously considered.

7. ASHONPLAFA should continually remind its staff to think of all clients as potential family planning customers and to offer appropriate family planning information and assistance to them.

8. ASHONPLAFA should continue with the remodeling and upgrading of all regional and satellite clinics.

9. ASHONPLAFA should continue promotional activities in urban areas, especially among potential middle-class clients, to overcome its image problem and to inform people of the broader range of health services now available.

10. ASHONPLAFA should examine the feasibility of setting up numerous satellite clinics, especially in urban areas, where middle-class clients are most likely to be found.

11. ASHONPLAFA should consider reorienting its self-financing strategy to focus on sustaining critical family planning and reproductive health outcomes rather than inputs.

**CYP Achievement**

1. ASHONPLAFA should continue to promote its reproductive health services, including sterilization and IUD methods, among middle-class and urban women.

2. ASHONPLAFA needs to find ways to serve low-income and rural women if CYPs are to increase significantly. The most direct approach would be to reduce prices for these women and to provide more promotion and transportation to clinics.

3. ASHONPLAFA should monitor the impact of the shared-risk system on profit and loss and CYP production, especially for the Tegucigalpa and San Pedro Sula medical and clinical services.

4. The Social Marketing Program (SMP) should remain exactly where it is organizationally within ASHONPLAFA, as a companion to other sales efforts and the Community Services Program.

5. Further development of the SMP should continue with the planned introduction of IUDs; non-family planning products; and possibly, injectable contraceptives.

6. USAID should make every effort to eliminate, or at least minimize, the unintentional competition with SMP from other USAID-funded programs.

7. If increasing contraceptive prevalence in rural areas is really a priority, ASHONPLAFA will need to invest in promotion and services for the rural poor. Vehicles and promotional equipment should be provided to reproductive health promoters so they can visit rural areas and carry out their education and information activities. Arrangements also need to be made to either bring family planning and reproductive health services to the communities or to bring clients to the clinics. Alternative sources of funding should be identified and explored, even if special funding is available from USAID.

8. USAID should structure the PVO grants to optimize collaboration among the PVOs, ASHONPLAFA, and the MOH so that each contributes what it does best in providing family planning services to the PVO target population.

**Support Systems and Other**

1. ASHONPLAFA should continue to improve and streamline its various management information systems. Training in advanced data for decision making should be provided to all regional and central managers.

2. ASHONPLAFA should not collaborate with PASMO in distributing the VIVE condom. Instead, they should explore a cooperative arrangement whereby PASMO would invest its resources in promoting the use of condoms to prevent the spread of HIV/AIDS.

3. ASHONPLAFA should develop or update its strategic plan to reflect its sustainability objectives with respect to decentralization, expansion of services to rural areas, inclusion of HIV/AIDS and maternity services, and staffing patterns. ASHONPLAFA should identify technical assistance needed to implement that strategic plan.

4. USAID should encourage the Reproductive Health Working Group to continue what it is doing.

5. ASHONPLAFA should continue its organizational transition to its conclusion. Management openness, communication, feedback, and encouragement also need to be continued.

# 1. INTRODUCTION

## 11. Overview of the Private Sector Population III Project (PSP III)

The Private Sector Population III Project (PSP III) was authorized on September 27, 1995, and is scheduled to end on December 20, 2000. The primary implementing agency for the project is the Honduran Family Planning Association (ASHONPLAFA). In 1997, USAID signed Cooperative Agreements with two Private Voluntary Organizations (PVO): Save the Children Association, Honduras (ASCH) and Programs for the Development of Infants and Women (PRODIM). Funding consists of $11.3 million from USAID and $13.4 million in counterpart funding from ASHONPLAFA.

PSP III is expected to contribute to USAID's Strategic Objective of "Improved Family Health" by helping to reduce the total fertility rate (TFR) from 4.7 in 1995 to 4.2 by 2001. This reduction is to be achieved by increasing the use of reproductive health services, including family planning, among women of fertile age. Total contraceptive prevalence is to increase from 50.1 percent in 1995 to 54.6 percent in 2000. At the same time, ASHONPLAFA's financial self-sufficiency is expected to increase from 31 percent in 1995 to 63 percent by 2001.

PSP III consists of two components: The first is support to ASHONPLAFA in medical clinical services; community-based distribution of temporary contraceptives; social marketing of temporary contraceptive methods; and information, education, and communication (IEC). The second is support to ASCH and PRODIM in IEC, limited medical/clinical services, transportation and referral, and training. The project also provides extensive technical assistance, contraceptives, and extensive training and limited equipment to ASHONPLAFA and the PVOs.

This evaluation[2] focuses almost exclusively on ASHONPLAFA's program, which consists of six regional offices with clinics that offer a variety of reproductive health services in addition to family planning. There are seven satellite clinics as well, which offer a smaller range of services. A Community Services Program, made up of over 1,600 local family planning posts around the country, sells low-priced condoms and pills, mostly in rural and periurban areas. A Social Marketing Program sells condoms and pills in urban areas. IEC provides a variety of mass-media advertisements; written and audiovisual materials; and personal promotion through meetings, seminars, and conferences. ASHONPLAFA's central office provides support to these programs through research, evaluation, training, management information assistance, as well as through such administrative functions as finance, logistics, and personnel.

Three regions of the country are emphasized under PSP III: The first two are the department of Olancho (Region VI) and the western region of the country (Region V), consisting of the departments of Lempira, Copán, Ocotepeque, Intibucá, and Santa Bárbara. These regions are

[2] POPTECH conducted this evaluation based on a request and funding from USAID/Honduras.

being targeted because of low modern contraceptive use and high maternal mortality. The third region is the nine Health Areas that are supported under the Health Sector II extension, where special efforts are to be made to ensure Ministry of Health (MOH) and PVO collaboration in implementing reproductive health activities.

## 1.2 Purpose of the Evaluation

An evaluation of the prior project (Private Sector Population II) was conducted in November 1994.[3] Many of the recommendations were incorporated in the design of the current project. This midterm evaluation of ASHONPLAFA's activities is designed to assist USAID/Honduras and ASHONPLAFA in making adjustments, if necessary, to the ongoing project and to provide direction for follow-on activities. The broad objectives of the evaluation are to (1) determine the degree to which the project is contributing to USAID's Strategic Objective of "Improved Family Health"; (2) identify implementation constraints and propose recommendations for overcoming them; and (3) identify activities that will contribute to the Mission's new health objective for 1998-2003, "Sustainable Improvements in Health."

Given that an Annual Results Review (ARR) was recently conducted (November 1997)[4] and that ASHONPLAFA was found to be doing well in many areas—37.5 of the 46 benchmarks for 1997 were exceeded or met—the evaluation team has been asked to focus on two major, interrelated issues with a view toward the future:

(1) Financial self-sufficiency and
(2) Couple-years of protection (CYP)/Contraceptive Prevalence Rate (CPR) achievement.

The Scope of Work (SOW) for this evaluation asked the team to respond to a number of specific questions under these two topics, in addition to several other questions. The questions and the team's responses are found in Chapters 3, 4, and 5. The questions are also summarized in Section 1.4.

[3] Laurel Cobb, et al. *Evaluation of the USAID/Honduras Private Sector Population II Project*, POPTECH Report No. 94-015-023, July 1995.

[4] "SO3 1997 Annual Results Review (ARR) and Issues," USAID/Honduras Memorandum, November 21, 1997.

## 1.3 The Demographic, Economic, Political, and Social Context of the Project

The most recent national Epidemiology and Family Health Survey (EFHS) was conducted in 1996 and showed that the total fertility rate (TFR) had declined from 5.2 in 1989-91 to 4.9 in 1993-95. Most of this decline was attributed to an increase in contraceptive prevalence—from 40.6 percent in 1987 to 50.0 percent in 1996. However, urban fertility in Tegucigalpa and San Pedro Sula (3.1) differs significantly from rural fertility (6.3), and fertility among women with seven or more years of education (2.9) differs significantly from that of women with no formal education (7.1). It is clear to all concerned that further reduction in fertility rates will need to occur among less educated and rural women.

ASHONPLAFA began providing limited family planning services 35 years ago with assistance from the International Planned Parenthood Federation (IPPF), the Pathfinder Fund, AVSC International (AVSC), and other organizations. The MOH has provided limited family planning services with USAID assistance since 1976. USAID provided support for substantial expansion into a six-region national program in 1985. In 1990, the MOH adopted a "reproductive risk" approach that targeted "high-risk" women—those under 18 or over 35 years of age, those of high parity, and those pregnant less than two years ago. Recently, the MOH has also begun to increase provision of family planning services in its hospitals and clinics. The government has allowed private organizations to expand their family planning programs, and there are no restrictions on the import or sale of contraceptives by pharmaceutical companies. However, the government has not developed a population policy, nor has the MOH developed a family planning service policy. Also, obstacles still exist. For example, age and parity requirements prevent women who want a sterilization from obtaining one. The MOH and government commitment to and support for family planning is very conservative and does not fully address the reproductive needs of the population, which is a major topic of the Health Sector II project evaluation.

A principal reason for this lack of commitment and support is the opposition of the Catholic Church to all forms of "artificial" contraception. This is, more than anything else, a political obstacle, since the EFHS showed that over 70 percent of family planning acceptors were Catholic and less than two percent of nonusers cited religious objections as the reason they do not use contraception.

## 1.4 Scope of Work for the Evaluation and Team Composition

USAID requested that the Health Sector II and the Private Sector Population III projects be evaluated simultaneously. The SOW directed the PSP III evaluation to "focus on answering the following questions":

Sustainability

1. Do regional offices have increased latitude to plan and manage their programs?

2. Do the regional managers need additional training? If so, what kind?

3. Should the central staff be reduced? If so, how?

4. What else can ASHONPLAFA do to reduce its operating costs without jeopardizing quality?

5. Which new non-family planning services are not profitable? Should they be dropped? Can they be made profitable?

6. What new non-family planning services could be added to increase profitability?

7. Are the clinic facilities and staff appropriate for middle-class clients?

8. What can ASHONPLAFA do to increase middle-class use of private sector services?

9. How should "financial self-sufficiency" be defined?

CYP Achievement

1. Why has CYP achievement declined over the past two years? What can be done to reverse this trend?

2. How does the "shared risk" compensation system in the Medical/Clinical program affect CYP achievement?

3. What can be done to ensure that ASHONPLAFA continues to focus on family planning as it diversifies?

4. Should the Social Marketing Program be continued? How would discontinuing this program affect ASHONPLAFA's CYP and self-financing goals?

5. What can the Community Services Program do to increase contraceptive prevalence in rural areas without sacrificing self-sufficiency?

6. Which would yield greater rural coverage: awarding grants to two more PVOs in 1998 to establish reproductive health services, or expanding ASHONPLAFA's rural family planning services?

7. How well are PRODIM and ASCH working with ASHONPLAFA and the MOH?

Support Systems

1. How well are the management information systems in the central and regional offices being used for planning and decision making? How can they be strengthened?

2. Should ASHONPLAFA collaborate with PASMO in distributing the VIVE condom, or should it market its own HIV/AIDS condom? What level of coverage is ASHONPLAFA likely to achieve?

3. In which areas will ASHONPLAFA need technical assistance in the future?

4. How effective is the reproductive health group?

Several additional questions were added in response to issues raised during the initial briefing with USAID. The following are addressed in the report:

Other Questions

1. Human Resources: How well are efforts in this area contributing to sustainability?

2. Research and Evaluation: Are the studies producing the results needed to aid managers in making decisions?

The Population Technical Assistance project (POPTECH) recruited a team of eight specialists, most of whom were assigned to the Health Sector Population II evaluation. One team member, the family planning program sustainability specialist, was assigned full-time (six weeks) to the Private Sector III project and took responsibility for preparing this report. Findings were shared during team meetings. Input from the team leader on human resources and from the maternal and infant health consultant on the quality of medical care were incorporated into this report. The complete list of team members, their roles, their length of time in Honduras, and their assignments are as follows:

Frank Sullivan, team leader (6 weeks) . . . . . Health II

Jack Reynolds, family planning program sustainability specialist (6 weeks) . . . . . PSP III

Fernando Gomez, family planning program specialist (5 weeks) . . . . . Health II

Mario Ganuza, management and systems analyst (4 weeks) . . . . . Health II

August Burns, maternal and neonatal specialist (4 weeks) . . . . . Health II

Bernardo Uribe, logistics specialist (3 weeks) . . . . . Health II

Patricia Paredes, child survival specialist (3 weeks) . . . . . Health II

Doreen Salazar, water and sanitation specialist (3 weeks) . . . . . Health II

### 1.5 Methodology

The team's work began May 18, 1998, with a two-day team planning meeting to orient all of the members to the two programs, review the SOW with USAID officials, develop an approach, make assignments, prepare a schedule, identify sources of information, plan field trips, and prepare outlines of the final reports.

The team collected data from ASHONPLAFA managers and staff in the capital and in the field, from documents supplied by USAID and ASHONPLAFA, from observation of services, and from numerous interviews with a range of stakeholders in all of the regions. The team conducted field visits to regional offices, clinics, and posts in the second and third weeks. Additional interviews were conducted in Tegucigalpa in the third and fourth weeks. The team briefed USAID and ASHONPLAFA in the fifth week just before delivering the first draft of the report. Revisions were made in the sixth week, and the draft of the final report was submitted simultaneously to USAID and POPTECH on June 27.

# 2. SUMMARY OF PROGRAM ACHIEVEMENTS

## 2.1 Intermediate Result 3.1: "Increased Use of Reproductive Health Services Including Family Planning"

Intermediate Result (IR) 3.1 has two indicators, only one of which applies to family planning: "Increased contraceptive prevalence in women 15-44 years of age, in union." As noted in Chapter 1, the project objective is to increase the CPR from 50.1 in 1995 to 54.6 percent by the end of 2000. Because the CPR can only be determined by national surveys, the proxy measure of CYPs is used in the interim years. Table 1 shows the original CYP objectives and achievements to date. Unfortunately, this table lacks some data because (1) the CYP indicator was not used in the first two years, (2) the CYP conversion factors were changed each year from 1994 to 1997 (only the achievement data have been standardized), and (3) the objectives were reset in 1996 to maintain the 1995 level of CYPs.

**Table 1**

**CYP Objectives and Achievements, 1995-2000**

| | 1995 | 1996 | 1997 | 1998 Projection* | 1999 | 2000 |
|---|---|---|---|---|---|---|
| Original Objectives | NA | NA | 198,976 | 266,773 | 281,489 | NA |
| Achievements** | 207,495 | 172,607 | 157,770 | 171,400 | | |
| Difference | | | 41,206 | 95,373 | | |
| Percent of Objective | | | 72.3% | 64.2% | | |
| Revised Objectives | | 207,495 | 207,495 | 207,495 | 207,495 | 207,495 |
| Percent of 1995 CYP | | 83.2% | 76.0% | 82.6% | | |

*1998 projection based on first quarter x 4.
**Standardized using 1998 conversion factors.

Nevertheless, the declining trend in achievement concerns USAID. However, first quarter data for 1998 indicate that the trend may be reversed this year. The reasons for the decline and prospects for the future are discussed in Chapter 4.

The 1996 EFHS provides some useful information regarding the characteristics of the CPR data (see Appendix D, Table D-1). Prevalence and modern method use has been increasing about one percentage point per year. Female sterilization remains the most popular method, followed by IUDs and oral pills, affirming the importance of making clinical services both available and accessible. The distribution of use by age and number of living children shows a reasonable level

of use among younger and lower parity women, indicating that the program (including sterilization and IUDs) is acceptable to these women. Data on religion and religiosity indicate that these factors have no part in the decision to use contraception. The factors that do make a difference are education, socioeconomic status, and area of residence. Data indicate that if contraceptive prevalence is to increase, the program needs to target women who are uneducated, women who are from the lower socioeconomic class, and women who live in rural areas. The data also show that ASHONPLAFA is the leading provider of family planning services in the country, accounting for more than the entire public sector. Unless the MOH steps up its family planning efforts, ASHONPLAFA will not only have to retain its current level of service, but will have to increase its level of service if prevalence is to rise, especially in rural areas.

## 2.2 ASHONPLAFA Benchmarks

ASHONPLAFA has many benchmarks to meet each year. Table 2 lists the number that were exceeded, met, and unmet according to the most recent Annual Results Review (ARR). A full list of benchmarks is included in Appendix D, Table D-2.

**Table 2**

**Benchmark Achievement, 1997**

| | Benchmark | | | |
|---|---|---|---|---|
| **Program** | **Total** | **Exceeded** | **Met** | **Fell Short** |
| Medical/Clinical Service Program | 13 | 2 | 9 | 2 |
| Social Marketing Program | 9 | 0 | 7 | 2 |
| Community Services Program | 10 | 0 | 7.5 | 2.5 |
| IEC | 2 | 0 | 0 | 2 |
| Support Systems | 12 | 0 | 12 | 0 |
| Total | 46 | 2 | 35.5 | 8.5 |

*Source:* "1997 Annual Results Review Report," pp. 15-17.

The two benchmarks that were exceeded were an increase in new users of non-family planning services and clinics switching to the use of contracted personnel. Those that fell short were increased CYPs produced by the Medical/Clinical Services Program (MSP), increased number of vasectomies performed, increased self-sufficiency of the Social Marketing Program (SMP) (now exceeded), increased sales of the Piel condom (now launched), implementation of the CSP needs assessment recommendations (now completed), restructuring of the *consejera* training program (now completed), and completion of two national IEC campaigns (now completed).

Thus, with the exception of CYP achievement (which includes vasectomies), the program is meeting its benchmarks quite well.

## 2.3 Other Achievements

The new San Pedro Sula Regional Center and clinic was opened in 1997 and is now almost fully operational. The center provides a range of diversified services in addition to family planning, and it seems to be attracting men and women who are willing and able to pay for these services. Plans are underway to add a full pediatric clinic and a psychologist to provide counseling services.

Satellite clinics were opened in 1997 in La Entrada and El Progreso. Two other clinics are planned in Lima and possibly Choloma, both in the San Pedro Sula region.

A quality assurance (QA) program has been institutionalized. Each region has a QA committee. As a result of this program, there have been significant reductions in client waiting time; improved patient flow; and extension of clinic hours to afternoons and, in some cases, to Saturday mornings. Waiting areas have been improved and client exit-interview studies show that these improvements are appreciated and have raised client satisfaction markedly.

## 2.4 Constraints on Achievement

One of the biggest constraints to achieving the IR 3.1 objective is the shortage of resources to extend services into rural areas. As described in Chapters 3 and 4, the incompatibility of the self-financing and CPR/CYP goals forces ASHONPLAFA to choose one over the other. Right now, the project has chosen self-financing. Such a choice would not be as big a problem if the MOH were willing and able to take over responsibility for providing services to rural, poor, and uneducated women. Whether the MOH will take over the responsibility is one of the topics of the Health Sector Population II evaluation. If the MOH does not take over, ASHONPLAFA is the only alternative.

The Honduran Social Security Institute (IHSS) is limited to urban areas, and the employees that it covers are not rural, poor, or uneducated. There are no private sector family planning clinics to speak of outside of urban areas, and those that do exist are unlikely to provide services to couples who cannot afford to pay for them. Few local Private Voluntary Organizations (PVO) work in the rural areas, and those that have been contracted to provide reproductive health care are limited to small geographic areas. They are not likely to extend their services throughout a region, let alone to all rural areas in the nation.

Significant cultural constraints also exists. Acceptance of family planning is quite good along the north coast, because of the more liberal and modern views of the people who have migrated to that zone. In contrast, the people of Olancho are known to be fiercely independent and

conservative. The area is called the "Wild East" of Honduras, and the residents call the region "The Independent Republic of Olancho." This department, which is the largest in Honduras (and one of the least populated), accounts for 20 percent of the country's territory, but has only one small ASHONPLAFA clinic, which offers limited services and is greatly underused. Yet, Olancho is one of ASHONPLAFA's two priority regions.

The other priority region, Copán, is at the opposite end of the country, bordering El Salvador and Guatemala. It is extremely mountainous, and, therefore, travel is difficult. It is one of the poorest parts of the country, inhabited mostly by poor, uneducated and extremely conservative subsistence farmers who have been under the influence of local priests for hundreds of years.

As noted in Chapter 1, the Catholic Church is very influential in Honduran politics. Although many MOH medical professionals support family planning, they are powerless to bring about a change in MOH policy to actively support and promote family planning. Little support for such a change is provided by their chief advisors at the Pan American Health Organization (PAHO) and the United Nations Population Fund (UNFPA).

To mount a successful family planning program under these conditions is extremely difficult and politically sensitive. When viewed in this context, ASHONPLAFA's achievements are remarkable. As it struggles to become financially self-sufficient, it is knowingly (and reluctantly) giving up some hard-earned achievements in service provision and coverage. ASHONPLAFA will definitely be challenged to find ways to regain some of that lost ground while continuing to reduce costs and expand non-family planning services for urban, middle-class clients.

# 3. SUSTAINABILITY

## 3.1 Overview of Findings

USAID has long been concerned about ASHONPLAFA's ability to continue providing essential family planning services after donor funding ends. As funds have become more difficult to secure, and funding has become increasingly dependent on the achievement of results, USAID/Honduras has become even more concerned about ASHONPLAFA taking responsibility for its own funding. Thus, in addition to the normal objective to increase contraceptive prevalence, in its project paper of September 29, 1995, the PSP III project also called for ASHONPLAFA "At the same time...(to) increase...self-financing from 31 percent in 1995 to 63 percent in the year 2000."[5]

This increase was to be accomplished by a combination of cutting operational costs, increasing charges for services, and adding new services that would increase income. Strategies were developed for each of the three program areas: (1) medical/clinical services, (2) community services, and (3) social marketing. As the data presented in this report demonstrate, ASHONPLAFA has done a remarkable job, especially in the past year, of implementing all of the self-sufficiency strategies. The association seems obsessed with finding ways to reduce costs in every aspect of its work, from curtailing telephone calls to closing unproductive rural family planning posts. Prices of all services and products have been studied and adjusted accordingly: although they have been raised, they are still competitive. Diversification of services has been embraced enthusiastically and even the smallest clinics now offer additional non-family planning services and medical products. The larger clinics have expanded their services to provide general medicine, gynecology and pediatric consultations, and laboratory services.

[5] "Project Paper: Private Sector Population III Project (522-0389)," p. 1, September 29, 1995.

**Table 3**

**Percent of Financial Self-Sufficiency, 1995-1998***

| | 1995 (%) | 1996 (%) | 1997 (%) | 1998(1/4) (%) |
|---|---|---|---|---|
| **Total** | **30.6** | **42.6** | **49.6** | **76.6** |
| Medical/Clinical Services | 54.3 | 62.4 | 79.8 | 113.8 |
| Community Services | 66.1 | 89.8 | 113.7 | 133.9 |
| Social Marketing | 109.3 | 96.6 | 69.8 | 182.0 |
| Support Services | 0.3 | 1.2 | 1.4 | 4.7 |
| Administration | 10.8 | 13.2 | 31.6 | 16.1 |
| Central Office | 21.3 | 22.6 | 28.7 | 58.7 |
| Region I, Tegucigalpa | 41.0 | 57.9 | 74.0 | 84.7 |
| Region II, San Pedro Sula | 39.0 | 65.4 | 57.6 | 91.0 |
| Region III, Choluteca | 40.3 | 49.8 | 60.5 | 72.7 |
| Region IV, La Ceiba | 43.4 | 66.4 | 66.0 | 92.9 |
| Region V, Copán | 32.1 | 49.5 | 53.3 | 80.9 |
| Region VI, Juticalpa | 26.4 | 42.3 | 58.8 | 96.8 |

*1998 data are for the first quarter only (January-March).
Note: See Appendix D, Tables D-3 and D-4 for details.

These strategies have affected financial self-sufficiency significantly. ASHONPLAFA has gone from 24 percent self-sufficiency in 1994 to 76 percent as of the first quarter of 1998. As Table 3 shows, progress has been made in every program and every region, even in Central Support Services (Research, IEC, Training) and Administration (Finance, Human Resources, Administration, Planning), which are not usually expected to raise money. How much further management can, and should, take those strategies is a critical question that will be examined in Chapter 4.

This chapter addresses important questions raised in the SOW issues of sustainability: (1) decentralization and the role of the regional chiefs, (2) their management capability, (3) cutting central staff and operating costs, (4) diversifying services, (5) attracting middle-class clients, and (6) defining what is meant by financial self-sufficiency.

## 3.2 Questions and Responses

**1. Delegation to Regional Offices: To what extent has the administrative reorganization of ASHONPLAFA increased delegation of authority from the central office and given the regional offices increased latitude to plan and manage their programs?**

Findings

**Table 4**

**ASHONPLAFA Decision-Making Authority (selected functions)**

| Function | Regional Chief Role | Approval |
|---|---|---|
| **Budget** | Proposes | Board and executive director |
| Line Item Change >15% | Proposes | Budget Committee |
| Line Item Change < 15% | Proposes | chief, Regional Division |
| **Purchasing Limit** | | |
| L 7000 | Choluteca, Copán, Olancho | NA |
| L 10,000 | La Ceiba | NA |
| L 12,000 | TGU, SPS | NA |
| L 40,000 | Proposes | chief, Admin./Finance Division |
| L 250,000 | Proposes | executive director |
| >L 250,000 | Proposes | Board |
| Contracts | Proposes | Board and executive director |
| Per Diem | Approves | NA |
| Checks | Approves | NA |
| **Personnel** | | |
| Hire, Transfer, Fire | Recommends | Board and executive director |
| Compensatory Time | Approves | NA |
| Vacation | Approves | NA |
| Merit Evaluation | Approves | NA |

All of the regional chiefs (they are not directors) say that the system is much better now than it was before. It is more open, more supportive, and more responsive, and decisions are made faster. But authority is still largely centralized in Tegucigalpa. The regional chiefs probably have more involvement than before, and some more latitude, but not necessarily more authority.

Most decisions are still made in the central office: plans, budgets, prices, purchases, hiring of personnel, and so forth (see Table 4). But all of the chiefs say that the decisions are made much more quickly and that their recommendations are usually accepted. In staffing, for example, a regional chief will recruit candidates, conduct interviews, and then send the paperwork and a recommendation to Tegucigalpa. The recommendation is usually accepted and the approval given quickly. Annual budgets and plans are prepared by the regions, sent to the central office, and then negotiated in a meeting between the regional chief and the Tegucigalpa directorate.

A new organizational Manual de Organización (ASHONPLAFA, December 1997), describes the roles, responsibilities, and limits of authority for all of the key functions of each manager, including the regional chiefs. The manual is similar to its predecessor, but allows more latitude in decision making, for example, in the amount a chief can spend on a purchase without sending in a request for approval.

The central administrative offices, thus, retain most of the control over operations. However, in some cases, even the central offices do not have control because the project agreement with USAID sets out specific activities that must be carried out; procedures that must be adopted; and, especially, targets that must be met. Those stipulations further limit the flexibility of the regional chiefs and their ability to manage their own programs.

Nevertheless, the regional chiefs unanimously believe that the central office is more supportive and responsive than before, and they appreciate this change.

## Conclusions

The reorganization has led to increased involvement of the regional chiefs in planning and management, and some increase in decision-making latitude. However, decision-making authority is still largely centralized or dictated by the terms of the USAID-ASHONPLAFA project agreement.

## Recommendations

If decentralization of authority is an accepted goal, then specific steps need to be taken to shift authority for such functions as planning, budgeting, personnel, purchasing, and monitoring to the regions. It would probably be prudent to make such shifts over time. USAID should allow ASHONPLAFA more latitude to carry out its programs, focusing more on achievement of outcomes and less on detailed inputs and activities.

**2. Training of Regional Chiefs: Are the regional (chiefs) sufficiently trained to manage their programs? If not, what additional training do they need?**

Findings

All of the regional chiefs are experienced managers, but they have diverse backgrounds—administration, education, accounting, banking, and business; none are physicians. Their levels of experience also differ. Some are new to ASHONPLAFA; others have been with the organization for many years. Whether they are "sufficiently trained" is only part of the question. Just as important is whether they have the skills, temperament, common sense, ability, judgement, drive, and confidence to be good managers. It may be too early to tell, or at least too early to tell if the new executive director believes that the chiefs possess those qualities.

All agree that as managers, the regional chiefs need continuous training and exposure to new technologies, techniques, and ideas. ASHONPLAFA conducts an annual diagnosis of training needs, which includes the managers, and it is planning to conduct numerous courses for its staff to address priority needs. Among these, naturally enough, are those that relate to ASHONPLAFA's new vision: in particular, marketing, sustainability, strategic planning, personal management, and evaluation and monitoring.

Support and coaching from the executive director and the Board of Directors will also be important for the regional chiefs. Both will be looking for direction and feedback on how the chiefs are handling their responsibilities. Semiannual meetings held in a different region each time could be invaluable for interactive exchanges and learning. An executive development program, including a two- to three-day retreat for the managers could also help to build team spirit, commitment, and confidence. It is also important to keep in mind that not everyone can be a good manager. The regional chiefs need to be assessed on their performance just like any other employee. Those who do well should be rewarded; those who are consistent underperformers should be replaced.

Conclusions

Additional training for the regional chiefs will be needed, but training alone is not the solution. The chiefs will need an ongoing management development program that gives them an opportunity to grow and prove themselves as managers.

Recommendations

In addition to continuing with the regular training opportunities already planned, ASHONPLAFA should consider constructing a management development program for all senior managers, including the regional chiefs.

**3. Downsizing of Central Staff: If decentralization has occurred, is the maintenance of a large central staff justified? If not, what changes need to be made to downsize the central staff?**

Findings

As noted above, decentralization of authority is minimal so far. If such decentralization is to be phased in over the next two to three years, then central administrative functions, such as accounting, personnel, purchasing, and management information services (MIS), would be decentralized. These services would be reduced to a minimum at the central level. Although this reduction in services would result in a downsizing of central staff, the number of regional staff would increase to carry out these same functions. However, this does not mean that separate accounting, personnel, purchasing, and other "divisions" would need to be established in each regional office. Many of these functions would be supported by computerized systems and would be clerical functions. One person should be able to handle several functions. Other support functions, such as IEC, research, and evaluation, would be more efficient if run as central services.

It is important to maintain perspective in analyzing staffing patterns. ASHONPLAFA has a very top-heavy, centralized organizational structure for such a small operation. At least half of the staff are administrative and support personnel, but ASHONPLAFA has only 13 clinics, half of which are very small, one- to two-person operations. Social marketing is run out of Tegucigalpa, and the community services mostly run by themselves.

In examining staff reduction options, it would also be useful to consider the regional offices, as well as the central office. For example, unless more clinics are established, there seems to be little reason to have regional chiefs in the smaller offices.

ASHONPLAFA has already reduced the size of its central staff, although this reduction has largely been due to attrition. Significant cuts in personnel have already been made in all divisions, and more are expected. At some point, ASHONPLAFA will have to decide whether to eliminate one or more divisions (the Information and Communications Division [DINCO] or Research and Evaluation, for example) because they will reach a bare minimum of staff at some point. Rather than setting an arbitrary number of staff as the goal to reach by 2000, it would be better to examine each function and determine its optimum staffing pattern. ASHONPLAFA has been innovative in introducing alternative staffing mechanisms. Examples are the shared risk system for physicians and the contracting of cleaning services. It would be important to examine these and other options for each function.

Conclusions

ASHONPLAFA has already made significant staff reductions at all organization levels. Further reductions are expected, but it is not clear how such reductions will be implemented.

ASHONPLAFA does not seem to have a master staffing plan for the organization that covers clinics, regional offices, and central staff.

Recommendations

ASHONPLAFA should decide what level of decentralization it will employ. Once this decision has been made, ASHONPLAFA should develop a master staffing plan that specifies the number and type of personnel to be employed at the clinic, regional, and central levels, and the most efficient mechanisms for doing so.

**4. Reducing Operating Costs: To a certain extent, ASHONPLAFA has been successful in reducing its operating costs. What additional steps can ASHONPLAFA take to further reduce operating costs and increase productivity and efficiency?**

Findings

The team observed that ASHONPLAFA has been very successful in reducing its operating costs. Costs have been cut significantly at every level. ASHONPLAFA has made significant reductions in such large cost categories as personnel, vehicles, transportation, and equipment. Impressive reductions have also been made in such recurrent costs as electricity, telephone, paper, water, and fuel. In addition, the association has implemented numerous cost-cutting innovations, such as reassigning a driver to become a contraceptive salesman to gasoline stations, and contracting for cleaning services rather than employing cleaners. Productivity and efficiency have been increased by combining tasks, such as using vehicles to deliver contraceptives and take promoters to rural sites on the same trip.

All association staff are involved in looking for ways to reduce costs while maintaining quality. Numerous meetings have been held to make staff at all levels aware of the need for cost reduction, and as a result, practically everyone seems to have bought into this ongoing campaign. An amazing change has occurred in the corporate culture, which until recently paid no attention to costs.

Cost cutting is only half of the equation, however. ASHONPLAFA is also trying to increase its revenues by raising prices and adding services. Thus, the fact that a region or service has high costs can be inconsequential if costs are offset by high revenues. The Social Marketing Program, for example, had very high costs in the first quarter of 1998 (L 1,222,763), but it had higher revenues (L 1,577,223), which translated into a profit of L 354,460, ten times more than the next highest profit center, the Danlí clinic. Thus, the profit margin, or self-financing percentage, is a more meaningful measure than cost reduction alone.

Each region and each department has its own objectives for costs, revenues, and expenses. Data on all of these, and a calculation of self-financing, is prepared and distributed every two months to

all of the managers, including the satellite clinics. These data are examined carefully and taken seriously. The results are impressive.

Data for the first quarter of 1998 show that ASHONPLAFA had revenues of L 6,245,950 and expenses of L 8,264,373, yielding a self-financing rate of 76 percent.[6] The goal for the project is only 63 percent by the end of 2000. If ASHONPLAFA can maintain this pace, the association could reach 82 percent self-financing a full two years before the project end date. It would be 19 percentage points over the target.

An examination of program revenue and cost data for the first quarter of 1998 shows that 12 of the 13 clinics, 5 of the 6 regional community service programs, and the Social Marketing Program are over 100 percent self-financing. That is, the revenue they generate more than offsets their direct and indirect costs. The problem is the indirect costs incurred by the central support and administrative divisions, which have little direct income and high costs. When these costs are allocated across programs, the overall level of self-financing drops to 76 percent.

These data should make it clear that operating costs are a significant burden at the central level, but not at the clinic level. Most of the clinics and community service programs are profitable. The central administrative and support divisions are not. Because those divisions do not make enough money to support themselves, the only options are to cut their costs or to increase revenues at the program level. ASHONPLAFA is doing well in both areas, but the potential for cost reduction may be limited. Program cuts are already affecting services. It may be time for ASHONPLAFA to step back to examine just how much further it wants to go, and at what pace.

Conclusions

ASHONPLAFA's cost-cutting efforts have been impressive and have produced amazing results in a short time. However, further cuts in program costs may be counterproductive. The deficits are due to administrative and support costs, not to program operating costs.

Recommendations

ASHONPLAFA should emphasize cost reductions at the central level and revenue generation at the program level. Additional cost cutting at the satellite clinic and community services level should not be pursued, except for obvious inefficiencies. Instead, these programs should be encouraged and assisted to increase client load.

**5. Diversified Services and Profitability: ASHONPLAFA has diversified its services to improve its self-sufficiency profile. However, not all of its diversified services are profitable. What needs to be done to make these services profitable? If some current**

[6] This rate includes both direct and indirect costs.

**services will never be profitable, should they be dropped? What additional non-family planning services would be feasible for ASHONPLAFA to offer to improve its profitability?**

Findings

ASHONPLAFA has provided diversified services since the PSP III began in 1995. As Table 5 shows, they are all health services, and most are reproductive health services. In the current environment, the family planning program is expected to provide a broad range of exactly those types of services. Therefore, it would be fair to say that ASHONPLAFA is complying with that trend. However, not all of the clinics provide all of these services. In fact, the satellite clinics provide few diversified services, and the number of services provided by the regional clinics varies. See Appendix D, Table D-6 for a list of services provided by each region.

**Table 5**

**Diversified Services, 1995-1998 (in units of services provided)**

| Type of Service | Years | | | Increase (1) (%) | Quarters | | |
|---|---|---|---|---|---|---|---|
| | 1995 | 1996 | 1997 | | 1997 (1/4) | 1998 (1/4) | Increase (%) |
| Cytology | 39,411 | 45,815 | 56,666 | 44 | 13,124 | 14,334 | 9 |
| Gynecology | 5,382 | 7,235 | 14,488 | 169 | 2,431 | 3,928 | 62 |
| General Medicine | 745 | 2,641 | 6,991 | 838 | 1,183 | 3,197 | 170 |
| Hematology | 7,025 | 6,650 | 6,010 | -14 | 1,536 | 1,271 | -17 |
| Prenatal | 2,598 | 1,940 | 2,849 | 10 | 673 | 670 | 0 |
| Pregnancy Tests | 1,562 | 2,364 | 2,152 | 38 | 616 | 588 | -5 |
| Ultrasound | 1,296 | 565 | 901 | -30 | 227 | 202 | -11 |
| Pediatrics | - | 202 | 457 | 126 | 57 | 201 | 253 |
| Infertility | 596 | 422 | 413 | -31 | 122 | 66 | -46 |
| Coloscopy | 156 | 218 | 403 | 158 | 69 | 127 | 84 |
| STD | 171 | 146 | 146 | -15 | 25 | 43 | 72 |
| Postnatal | 55 | 162 | 27 | -51 | 6 | 10 | 67 |
| Other Diagnostics(2) | 129 | 201 | 529 | 310 | 83 | 110 | 33 |
| Other Lab Tests(3) | 6,845 | 12,950 | 8,162 | 19 | 2,665 | 2,629 | -1 |
| Other Services(4) | 26,812 | 23,953 | 11,510 | -57 | 4,277 | 17 | -100 |
| **Total** | **92,783** | **105,464** | **111,704** | **20** | **27,094** | **27,393** | **1** |

(1) Increase from 1995 to 1997, except Pediatrics, which is 1996-1997.
(2) Other diagnostic tests include biopsies, cauterization, and crio surgery.
(3) Other lab tests include blood chemistry, parasitology, and urine.
(4) Other services include cytology result visits, pre-operation visits.

Whether each individual service is profitable may not be the most appropriate question. Health providers often include certain services that are unprofitable to offer a complete package of care or to attract new clients who may see "extra value" in a clinic that offers extra services at no extra charge.

This is not to say that ASHONPLAFA is doing either, but there is clearly a rationale for providing some services that are not very profitable, or that may even be "loss leaders," offered to attract

new customers. It is probably more useful to look at the larger package of diversified services and ask the following questions:

(1) Is the package as a whole making a contribution to self-financing?

(2) Are some of these services unnecessary?

(3) Are there some other services that should be added to fill a void or increase the attractiveness of the overall package?

It seems clear from Table 5 that most of the services currently offered are relevant. One could argue that prenatal, postnatal, and pediatric care are borderline services, but the first two are clearly related to reproductive health, and the third is a natural extension of the first two. The same cannot be said of dentistry, but the staff believes that a significant unmet need for that service exists, and that the service will be profitable. What is missing is child delivery, and ASHONPLAFA is seriously considering adding a small maternity or birthing service in at least three of its clinics—Tegucigalpa, San Pedro Sula, and La Ceiba. Although these services would be significant additions, they would be costly because they would turn the clinics into 24-hour centers and require a different class of providers. However, one member of the team visited a very successful and simple six- to eight-bed private birthing center in Potrerillos that is run by a midwife (a traditional birth attendant [TBA]). The center only takes normal births, but a physician is on call, just in case. This center could serve as a model for ASHONPLAFA. If ASHONPLAFA decides to open a 24-hour center, it could also add minor emergency care and a 24-hour pharmacy.

Table 5 also shows the presence of a significant demand for the diversified services, especially for cytologies, gynecology, and general medicine. Demand for the latter two has increased markedly in the last year. The number of cytologies performed accounts for half of all diversified services and averages around 220 per work day, or 11 per day per clinic. Gynecology services doubled in 1997 and are growing even faster so far this year. General medicine consultations, which almost tripled last year, are tripling again this year.

The diversified services are obviously popular. The 1997 study of the quality of care of ASHONPLAFA's medical services[7] noted that 83 percent of the clients interviewed came to the clinic for diversified services. As the report states, this is very encouraging for self-financing, and clearly demonstrates the attractiveness of these services.

The negative side of this is that these services do not directly produce any CYPs. They may lead to CYPs if the clients take advantage of the family planning products and services available to them at the clinic. Unfortunately, that did not seem to be happening as recently as late 1997,

[7] "Estudio Calidad de Atención y Satisfacción del Cliente Programa Médico Clínico." ASHONPLAFA, División de Investigación, Evaluación y Estadística. November 1997.

partly because the staff was not promoting family planning to these clients. The study report includes a very strong recommendation that every person who comes in for a diversified service should be offered family planning information and services as appropriate. This recommendation may have been heard, at least in some clinics. One member of the team followed 15 clients in the Tegucigalpa clinic and reported that, in addition to providing excellent service, the staff asked each client which method she was using and took the opportunity to provide information and counseling, as appropriate. However, in a smaller regional clinic the same team member observed that the nurse who took cytologies did not mention any other service that was available, including family planning. When asked about this omission later, the nurse thought it would be a great idea to mention other available services. This left unanswered the question of whether the nurse did not mention other available services because she did not think she should.

It seems that the diversification services are making a significant contribution to ASHONPLAFA's self-financing goal. Table 6 shows that when all 1997 family planning activities are grouped together (which ASHONPLAFA calls a "Strategy"), ASHONPLAFA almost broke even (97.6 percent self-financing). Nevertheless, ASHONPLAFA still suffered a net loss of L 228,837. The diversified strategy, on the other hand, had a net profit of L 3,281,032—205.4 percent self-financing. Just as impressive is that none of the diversified services lost money; they all made a profit. Three of the six family planning services, however, lost money.

**Table 6**

**Profit and Loss by Family Planning and Diversified Service Strategies, 1997 (in Lempiras)**

| Strategies | Income | Costs | Profit/ (Loss) | Rank Gross | Self-Financing (%) | Rank ROI |
|---|---|---|---|---|---|---|
| **Family Planning** | | | | | | |
| Surgery (MSP) | 987,799 | 1,955,622 | (967,823) | | 50.5 | |
| Permanent Method Consultations (MSP) | 106,719 | 365,957 | (259,238) | | 29.2 | |
| Temporary Method Consultations (MSP) | 1,032,405 | 6,925 | 1,025,480 | 2 | 14,908.4 | 1 |
| Community Service Program (CSP) | 5,039,836 | 4,734,859 | 304,977 | 7 | 106.4 | 8 |
| Social Marketing Program (SMP) | 1,628,984 | 2,335,194 | (706,210) | | 69.8 | |
| Contraceptive Sales (CSP) | 485,230 | 111,253 | 373,977 | 6 | 436.2 | 2 |
| Total | 9,280,973 | 9,509,810 | (228,837) | | 97.6 | |
| **Diversified Services** | | | | | | |
| Surgery (MSP) | 99,322 | 49,475 | 49,847 | 8 | 200.8 | 6 |
| Consultations (MSP) | 1,665,206 | 671,078 | 994,128 | 3 | 248.1 | 3 |
| Sales of Medicines (MSP) | 1,608,599 | 1,097,662 | 510,937 | 4 | 146.5 | 7 |
| Cytology Examinations (MSP) | 2,163,880 | 951,866 | 1,212,014 | 1 | 227.3 | 4 |
| Other Clinical Laboratory Examinations (MSP) | 745,001 | 343,872 | 401,129 | 5 | 216.7 | 5 |
| Sales of Other Products (MSP) | 12,967 | - | 12,967 | | - | |
| **Total** | **6,294,975** | **3,113,953** | **3,181,022** | | **205.4** | |

Note: Rank Gross = largest amount of profit; Rank return on investment (ROI) = best return per Lempira invested.

The ranking columns show that in terms of gross profit, the cytology examinations earned the most, followed by family planning consultations for temporary methods. In terms of "return on investment," the same family planning service was top, followed by contraceptive sales. Among the diversified services, consultations and cytology exams were the best investments.

The cost-accounting program that ASHONPLAFA uses now is new, so this type of information is not available for 1995 and 1996. Also, the program only allows six categories, so details on each diversification service cannot be generated. For example, all of the consultations are grouped together, so we cannot determine the profitability of gynecology, general medicine, pediatric, or

other consultations. ASHONPLAFA is planning to install a new cost-accounting program this year, which will allow ASHONPLAFA to compute profit data for as many services as it wishes.

The current system can generate quarterly data for 1997 to compare with 1998. Data from the first quarter of each year are included in Appendix D, Table D-5. However, these data must be interpreted with care, since seasonal variation may cause some components to look profitable in one quarter while unprofitable in another. And, as mentioned, the system does not allow us to examine each particular service (for example, gynecology or general medicine) because all of the services are grouped together under consultations.

However, we can identify the top revenue-generating services: cytology, generating L 2.2 million in 1997; sales of medicines, with L 1.6 million; gynecology, with L 1.2 million; clinical laboratory services, with L 0.7 million; and family clinics, with L 0.6 million. No figures were available for pediatrics and dentistry, but both services were projected to earn L 94 and 60 thousand each in 1998. It is important to keep in mind that these figures represent revenues only, we do not have cost data, so we cannot determine if these are the most profitable services.

Conclusions

The diversified services, as a package, are producing a very favorable return and can be expected to continue to do so. All of the services currently offered are relevant and are broadening ASHONPLAFA's reproductive health services in exactly the direction that one would wish. Dentistry is the exception, however. Maternity care is one obvious service that is not included as yet. An important reason for offering additional reproductive health services is to attract more clients to family planning. Some evidence shows that this is not happening in all clinics, particularly the smaller ones.

Recommendations

ASHONPLAFA should continue to expand its reproductive health services to as many clinics as possible. Maternity care, or low-tech, simple birthing centers, should be seriously considered. Dentistry services should be monitored closely to determine if they are really adding value to ASHONPLAFA clinics. Staff need to be reminded to think of all clients as potential family planning customers and to offer appropriate family planning information and assistance to them.

**6. Diversified Services and Middle Class Clientele: The diversified services are designed to attract middle-class men and women to ASHONPLAFA's facilities. Are the facilities suitable enough for this type of clientele? Are the persons who staff these services appropriate to deal with this type of clientele? What additional steps does ASHONPLAFA need to take to attract the middle class to its facilities?**

Findings

ASHONPLAFA is trying to attract "lower-middle" and "middle-middle" class clients, but not "upper-middle" clients. Those use higher-priced private providers. The lower- and middle-middle-class clientele are made up of teachers, factory workers, store clerks, government workers and others with steady, salaried positions. According to ASHONPLAFA's own research[8] and the observations of many of the frontline service providers, such middle-class clients are coming to ASHONPLAFA clinics and are satisfied with the facilities and staff. The key reasons for this satisfaction seem to be that ASHONPLAFA's clinics and services are better and cheaper than those in the private sector. The clinics are cleaner, more attractive, and more comfortable; the staff is more knowledgeable, more considerate, and more responsive; and the prices for products and services are much lower compared to most private sector medical clinics.

Much remodeling and upgrading of clinic facilities has already taken place, and more is planned. Most clinics have reorganized their layouts to improve patient flow, make waiting areas more comfortable, and expand services. Most have been newly painted. New furnishings have been purchased and vending machines have been installed so clients can purchase refreshments while they wait. Air conditioning has been installed in most clinics. Some clinics, such as San Pedro Sula, Tocoa, La Ceiba, El Progreso, and Santa Rosa de Copán, are bright, attractive, and modern looking. However, others, such as Puerto Cortés, La Entrada, Juticalpa, and Danlí, are in need of renovation. Such renovation is already underway in some of these clinics. The Puerto Cortés clinic, for example, is on the second floor of the sports stadium. The advantage of that location is that everyone knows where it is. The disadvantage is that the space is crowded, dingy, and poorly lighted. ASHONPLAFA is thinking of relocating the clinic to a more attractive space. Juticalpa is in a good location also, but there is no air conditioning in the waiting room or in several of the other rooms. Thus, it is extremely hot. The interior of the clinic is also in need of paint, renovation, and more comfortable furniture. However, all of these deficiencies are being corrected and even if they were not, most clients still think that ASHONPLAFA facilities are better than those of most other private providers.

The staff in these clinics is also well regarded, according to research findings on quality of services, and our own observations. All of the clinics we visited were either staffed by a professional nurse (bachelor's degree nurse), a physician, or both. All of the providers seemed qualified, experienced, competent, and sensitive. Promoters often assisted the principal provider, registered patients, provided information, sold medicines, or filled out forms. Most of these individuals were "reproductive health" promoters whose main job is to conduct health education and service promotion work in the field, both rural and urban. It seems to be a waste of their time and talent to use them for administrative work in the clinics. Apparently, this is a cost-saving measure, but they would be more productive (and probably more comfortable) in the field. Lower-salaried clerks could be hired as clinic assistants.

[8] "Estudio sobre Calidad de Atención y Satisfacción de Clientes del Programa Médico Clínico: Evaluación realizada a nivel nacional." ASHONPLAFA, 1997 (also 1996).

The assignment of promoters to clerical activities in some clinics is keeping them from doing all of the promotional work they were hired to do. That, in turn, is reducing demand for services in both rural and urban areas, since the promoters have less time to identify, counsel, and refer clients to the clinical services. Promotion was consistently identified as one of the greatest needs by clinic and promoter staff. Promotion is severely hampered, however, by a lack of vehicles, portable public address systems (loudspeakers), cassettes and cassette players, in addition to promoter time.

The greatest problem ASHONPLAFA has faced in attracting more middle-class clients is its image as a government agency that serves the poor. ASHONPLAFA has made efforts to overcome that image, starting with the research that identified it as a problem in the first place.[9] ASHONPLAFA has developed an image campaign directed at the middle class and conducted special promotional work aimed at the middle class, including radio and television announcements, talks to business groups, and even door-to-door canvassing. ASHONPLAFA staff believe those efforts are paying off in increased client visits, but such promotional work will need to continue for quite awhile if the new ASHONPLAFA image is to be ingrained in the minds of this target group.

The 1996 study of client satisfaction included a question about years of schooling, which can be used as an indicator of socioeconomic status. It showed that 32 percent of clients had secondary or higher education. Unfortunately, the 1997 study did not include this question, so we cannot determine whether the number of middle-class clients has increased. It would be useful to include such an indicator to determine if the program is, in fact, attracting more middle-class women.

## Conclusions

ASHONPLAFA's facilities and staff are suitable to attract middle-class clients. ASHONPLAFA is seen by those middle-class clients who have used its services as providing better and less expensive care than most other private providers. The problem, in both urban and rural areas, is the lack of adequate promotion to allow ASHONPLAFA to overcome its image as a government agency that serves the poor. Lack of information about services offered is a related gap.

## Recommendations

ASHONPLAFA should continue with the remodeling and upgrading of all regional and satellite clinics. Promotional activities should be continued in urban areas, especially among potential middle-class clients to overcome ASHONPLAFA's image problem and to inform people of the broader range of health services available.

---

[9] "Estudio sobre Conocimientos, Actitudes y Práctica de la Población (CAP): Estudio realizado con la asistencia de la Universidad Johns Hopkins," ASHONPLAFA, 1997.

**7. Increasing Private Sector Use: According to the 1996 survey data, a sizeable number of men and women who have the ability to pay for health services use the MOH services. The survey data also show that the use of private sector health services is low, especially in the two major urban centers of the country, Tegucigalpa and San Pedro Sula. What can ASHONPLAFA do to fill this void in the private sector?**

Findings

ASHONPLAFA is already doing a lot to attract clients who have the ability to pay for its services. These efforts will continue and can be expected to show results slowly over time, since it takes time and money to change a well-established image. Because ASHONPLAFA is trying to cut costs, the change can be expected to take longer than if the association had the funds available to invest in a larger image improvement campaign.

As noted, ASHONPLAFA is also diversifying its services to include comprehensive pediatric services in Tegucigalpa and San Pedro Sula. If successful, these services should attract more clients, including those who rely on the MOH.

Nevertheless, there are other opportunities that ASHONPLAFA should probably examine. Among the reasons that people who could afford to pay probably use MOH sources for contraceptives and services are the following:

- Few private physicians and clinics provide family planning services and contraceptives;
- Those that do are likely to be of poor quality and expensive; and
- ASHONPLAFA, the leading provider of high-quality, affordable services, has only one clinic in Tegucigalpa and one in San Pedro Sula—access is very limited.

In summary, many people who could use the private sector probably would if it were more accessible, reasonably priced, and of adequate quality. It seems strange that ASHONPLAFA has only one clinic in a city of 800,000 inhabitants. Given the rough terrain and poor transportation systems in Tegucigalpa, for example, it would seem reasonable for ASHONPLAFA to have numerous satellite clinics scattered around each city. ASHONPLAFA has conducted several feasibility studies in recent years, and it plans to open satellite clinics in several sites. However, the association may not have examined all of the options for financing such services. The clinics could be owned by ASHONPLAFA outright and staffed with professional nurses (with local physicians on call, as needed), but clinics could also be set up as franchises that could be sold to physicians or nurses, or contracted to physicians or nurses on a modified "shared risk" basis.

Other potential service delivery points (SDP) should also be examined, such as "women's clinics" in *maquilas*, other factories, and in plantation areas; ASHONPLAFA booths at local fiestas; or a

mobile unit that offers all methods and key reproductive health services. Brainstorming by ASHONPLAFA central and regional staff would undoubtedly yield other ideas.

It may also be worthwhile to consider several other ways to attract middle-class clients. Accepting payment via credit card, for example; qualifying as a provider for privately insured health care plans; and assignment of a "primary physician" for women who prefer to be seen by the same physician at each visit. In general, ASHONPLAFA should adapt a social marketing approach to the marketing of its services (not just its products) to middle-class clients.

Conclusions

ASHONPLAFA is already working to expand the use of private sector family planning services and contraceptives. However, ASHONPLAFA has few clinics, which limits access, especially in the major urban areas. Additional opportunities may be available to ASHONPLAFA for expanding its service network and attracting private nurses, midwives, and physicians to participate in providing family planning services.

Recommendations

ASHONPLAFA should examine the feasibility of setting up numerous satellite clinics, especially in urban areas, where middle-class clients are most likely to be found.

## 8. Defining "Financial Self-Sufficiency": What is the operational definition of financial self-sufficiency used by the PSP III project? How is it measured by ASHONPLAFA? How is it measured by family planning programs in other countries? Discuss any differences in definition or measurement methodology and make recommendation for ASHONPLAFA's case.

Findings

"Self-financing," "self-sufficiency," and "sustainability" are all used interchangeably in PSP III.[10] However, these three terms have different meanings. Self-financing means that the organization finances all of its costs with its own resources. Self-sufficiency means that no outside help is needed. Sustainability refers to the continual maintenance of something, which could be a program, an organization, an activity, even an input. There is no restriction on the source of support. The prefix "self" imposes a major restriction. In some countries, that is the objective—an organization gets to the point where it is able to operate without any outside assistance. In many other countries, that is not the case. The objective is often to "sustain" a program by whatever legal means available, including funding from taxes, other donors, and various non-project,

[10] In Spanish the terms are *auto-fianciamiento*, *auto-suficiencia*, and *sostenabilidad*.

income-generating activities. ASHONPLAFA's objective, to become completely self-financing, may not be the best objective.

There is some concern that ASHONPLAFA may not be measuring its self-financing status accurately. The association may not be including indirect costs, depreciation, and other costs. This does not seem to be the case: ASHONPLAFA now has a very comprehensive, but very simple, cost-accounting system that allows it to examine costs and income in various ways. The Administration and Finance Division produces several basic reports that allow ASHONPLAFA (and the regions, clinics, and central departments) to monitor the income and costs incurred by each program, service, and region. A clinic can therefore monitor its costs, income, and profit or loss each month, which is very useful because it gives the clinic information on the variables under its control. The division also produces data that distribute the indirect costs across all programs and regions, so that the managers can chart the organization's overall progress.

The division has very complete and detailed information on all costs and revenues (by source) and can produce a variety of other cost information on request. For example, it can prepare breakdowns of the amount of money that the Community Services Program spent on transportation in each region. It can produce such ratios as the cost per CYP, cost per employee, or cost per vehicle. The financial reports prepared by the division are easy to understand and widely used throughout the agency.

There is a problem, however, but it is not with the cost-accounting system. It is with the concept of "financial self-sufficiency." This measure focuses on money rather than results, and on inputs rather than outcomes. The self-financing approach does not specify what is and is not important to sustain. It merely calls for raising enough money (and cutting enough costs) to maintain the organization as it is, without regard for services and health outcomes. When cuts are made in costs the natural tendency is to cut expensive inputs, such as vehicles, equipment, and personnel because those are where the greatest savings can be made. ASHONPLAFA is making such cuts. Cuts have been made in these inputs with not enough regard to their effect on essential services and their resulting outcomes. That is one of the reasons for the serious shortages in vehicles, transportation, and promotion, all of which have caused declines in sterilization and IUD acceptance. At the same time, such income-generating services as cytology and pediatrics generate income (inputs) but have little or no effect on family planning outcomes.

A preferred approach is to start at the end of the input-outcome chain and work backwards, first determining which outcomes ASHONPLAFA wants to sustain (for example a CPR of *x* with a modern method mix of *y*). Strategies for sustaining those objectives would be developed, programs to carry out those strategies would be designed, and finally, the resources needed to support those programs would be identified. This is basically a planning exercise, but with the emphasis on sustaining selected outcomes, not on sustaining a given level of income.

The team does not suggest that ASHONPLAFA abandon its self-financing goals. Significant progress has been made and ASHONPLAFA is going in the right direction. However, it might

help to superimpose an "outcome sustainability" matrix on the current strategy. ASHONPLAFA could then reorient its self-financing strategy to sustain its most critical services.

## Conclusions

ASHONPLAFA's operational definition of "self-financing" is the ratio of income to costs, expressed as a percentage. The cost-accounting system is capable of measuring this percentage for the program as a whole and by program, region, and clinic. The system is comprehensive and simple. The reports produced are easy to understand and used extensively throughout ASHONPLAFA. Unfortunately, the self-financing approach forces the agency to concentrate on costs and income, rather than sustaining desired outcomes. An "outcome sustainability" framework might be a useful addition.

## Recommendations

ASHONPLAFA should consider reorienting its self-financing strategy to focus on sustaining critical family planning and reproductive health outcomes rather than inputs.

# 4. CYP ACHIEVEMENT

## 4.1 Overview of Findings

USAID has been equally concerned about ASHONPLAFA's ability to have an impact on contraceptive prevalence. The 1995 project paper states that Honduras is a family planning "plateau country," where the use of modern methods of contraception has grown slowly in recent years. Modern method use was 30 percent in 1984, 35 percent in 1991, and 41 percent in 1996. Traditional methods, however, grew from 5 percent in 1984 to 12 percent in 1991, but declined to 9 percent in 1996.

CYP is used as a proxy measure in the years between surveys. USAID's concern with the lack of progress was expressed clearly in the SOW for this evaluation: "The most unsettling problem that ASHONPLAFA has experienced since 1996 is its inability to maintain...CYP achievement at 1995 levels...only 76 percent of this goal was met in 1997."

Despite the fact that USAID has agreed that "ASHONPLAFA's principal goal is to reach self-sufficiency in the shortest time possible," and that "ASHONPLAFA's plans to expand services in an attempt to increase CYPs were put on the back burner," there is still hope that CYPs can be increased. The evaluation team has been asked to identify a way to "have our cake and eat it too," as one USAID official said. Is it possible to increase CYPs and self-sufficiency at the same time?

This chapter answers seven specific questions raised in the SOW about experience with "shared risk" compensation for physicians, cross-subsidies from social marketing, use of PVOs, and diversified services. The questions also ask why CYPs have declined and what can be done to increase them, especially in rural areas where the need is greatest.

## 4.2 Questions and Responses

### 1. Why CYP Achievement Has Declined: CYP achievement has declined over the past two years, particularly in the Medical/Clinical Program and the Social Marketing Program. What explains this decline and what can be done to reverse this trend?

Findings

Table 7 shows the changes in CYP achievement over the last several years. In 1996, total CYPs declined 17 percent; in 1997 they dropped another 8.6 percent. This year, the first quarter figures are encouraging. If this trend continues for the rest of the year, the CYPs should increase 8.6 percent and return to the 1996 level.

This recovery is primarily due to the recent success of the SMP, which is projected to reach 40,000 CYPs this year, an increase of 175 percent over 1997. The SMP will pass the Community Services Program (CSP) to become the second largest contributor to CYPs.

**Table 7**

**CYP Achievements* 1995-1998**

| | 1995 | 1996 | 1997 | 1998 Projection | 1998 1st Quarter |
|---|---|---|---|---|---|
| Total | 207,495 | 172,607 | 157,770 | 171,400 | 42,850 |
| Medical/Clinical Services | 129,374 | 106,044 | 94,709 | 95,172 | 23,793 |
| Community Services | 50,695 | 47,844 | 48,482 | 36,208 | 9,052 |
| Social Marketing | 27,426 | 18,719 | 14,579 | 40,020 | 10,005 |
| Region I, Tegucigalpa | 89,331 | 71,538 | 65,232 | 89,924 | 22,481 |
| Region II, San Pedro Sula | 54,181 | 44,285 | 40,766 | 37,856 | 9,464 |
| Region III, Choluteca | 14,143 | 11,228 | 10,563 | 8,132 | 2,033 |
| Region IV, La Ceiba | 21,789 | 23,225 | 21,650 | 18,832 | 4,708 |
| Region V, Copán | 12,151 | 13,629 | 14,733 | 12,376 | 3,094 |
| Region VI, Juticalpa | 10,900 | 8,702 | 4,826 | 4,468 | 1,117 |

*Standardized by 1998 conversion factors: VS = 10, IUD = 3.5, Injection = 4; Orals = 15, Condom = 120; Vaginals = 6.
Note: See Appendix D, Table D-7 for a detailed report on the first quarter CYP achievement by program and clinic.

The major producer of CYPs is the Medical/Clinical Service Program (MSP), which has also accounted for most of the decline in CYPs in the last few years. It seems to be leveling off this year, but is still 26 percent below the 1995 level.

MSP CYPs are heavily influenced by the number of sterilizations and IUD insertions performed. In 1995, these two methods accounted for 99 percent of MSP CYPs. The two methods still account for the same percentage in 1998, but the number of procedures has dropped significantly, which is the major reason for the decline in MSP CYPs. In 1995, these two methods accounted for 127,828 CYPs, but in 1998 they will only account for 92,700. That is 97 percent of the difference in CYPs between the two years.

The regional distribution of CYPs is discouraging. Only Region I looks like it will produce an increase in CYPs in 1998. All of the other regions have a projected decline. Comparing the 1995

target to the 1998 projection, only Regions I and V will match the 1995 target this year, and the latter's CYPs will actually decline compared to the 1997 target. Regions VI, III, and II are the furthest behind at 59, 43, and 30 percent below their 1995 levels, respectively.

From interviews with regional and field staff, three factors seem to account for the declines in IUD and VS procedures: (1) increases in prices, (2) reductions in promotion, and (3) reduction in transportation of clients to clinics. All three of these factors affected poor and rural women more than middle-class and urban women. Although this is understandable, even predictable, it is an unfortunate by-product of ASHONPLAFA's need to cut costs and increase income to become self-sufficient. Although CYPs are increasing now, efforts to increase sterilizations and IUD insertions among poor and rural people will still require affordable prices, promotion, and transportation.

Conclusions

The decline in CYPs was largely due to the decline in sterilization and IUD procedures. This, in turn, was largely due to three factors: (1) the increase in prices, (2) the reduction in promotion, and (3) the reduction in transportation of clients to clinics. These factors will have to be reversed if poor and rural women are to be given full access to these services.

Recommendations

ASHONPLAFA should continue to promote its reproductive health services (including sterilization and IUD methods) among middle-class and urban women. However, it also needs to find ways to serve low-income and rural women if CYPs are to increase significantly. The most direct approach would be to reduce prices for these women, and provide more promotion and transportation to clinics.

## 2. The Effect of "Shared Risk" on CYP Achievement: How does the new method of paying physicians (*riesgo compartido*, shared risk) affect CYP achievement of the Medical/Clinical program?

As a result of a study tour to Profamilia in Colombia and its own studies of the costs of medical and clinical services,[11] ASHONPLAFA decided to reduce payments to physicians for their services. A system of "shared risk" was introduced early in 1997 whereby the cost to ASHONPLAFA of supporting each service, such as facilities, equipment, and supplies) would be deducted from the fee and the remainder would be split between ASHONPLAFA and the physician who provided the service. Although the fee earned per patient by the physicians was

[11] These studies are conducted annually: for example, "Estudio de precios de los productos y servicios ofrecidos por los programas realizados en los seis Centros Regionales de la Asociación," ASHONPLAFA, 1995, 1996, and 1997.

effectively reduced, income could be made up by increased volume. At first, physicians had some resistance to this scheme and a few physicians decided to resign. Over time those who remained accepted the new system. Nevertheless, a weakness of this new shared-risk system is that since the physicians are not employees, they can leave any time, and some have. They may occasionally not show up for their session; take off a week for a conference or vacation; or worst of all, decide not to work for ASHONPLAFA anymore after they have received special training.

Findings

The shared-risk system has been an impressive success—financially. Both ASHONPLAFA and the physicians are making more money than previously, and the physicians are very happy. Furthermore, because their income is dependent on volume, physicians have an incentive to serve as many clients as possible during a clinic session[12] and to encourage new clients to come to the clinic. The addition of new services has helped the physicians by providing a larger client base and, therefore, greater volume. Both general practitioners and specialists benefit from the system. ASHONPLAFA has benefited from the system and from adopting a new policy to peg prices to inflation. Prices are reviewed every six months and revised accordingly.

The annual data presented in Table 8 show a significant increase in both income and costs for the medical and clinical services. Income rose 178 percent and costs rose 89 percent between 1995 and 1997. The medical services are still running at a significant loss, however, although they are past the project goal of 63 percent self-financing by 2000.

**Table 8**

**Medical/Clinical Program Costs, Income, and CYPS, 1995-1998**

| Medical Services | Years | | | Increase (%) | Quarters | | Increase (%) |
|---|---|---|---|---|---|---|---|
| | 1995 | 1996 | 1997 | | 1997 (1/4) | 1998 (1/4) | |
| Income | 3,258,534 | 4,938,729 | 9,050,500 | 177.7 | 1,958,231 | 2,937,578 | 50.1 |
| Expenses | 6,005,338 | 7,913,609 | 11,349,057 | 89.0 | 1,469,961 | 2,592,636 | 76.4 |
| Profit/(Loss) | (2,746,804) | (2,974,880) | (2,298,557) | -16.3 | 488,270 | 344,942 | -29.4 |
| Percent Self-Financing | 54.3% | 62.4% | 79.7% | | 133.2% | 113.3% | |
| CYP | 129,374 | 106,044 | 94,709 | -27.1 | 26,733 | 23,793 | -11.0 |

Note: See Appendix D, Tables D-3 and D-4 for details.

[12] To ensure adequate time is given to each patient, ASHONPLAFA norms limit the number of patients to be seen by a physician to four to six per hour, depending on the type of consultation.

The quarterly data show that MSP actually showed a profit in the first quarter of 1997 and 1998. That is unlikely to continue, however, since the expense budget for the year is over L 18 million, which averages out to L 4.5 million per quarter.

The major question is how does "shared risk" affect CYP achievement. CYPs attributable to the Medical/Clinical Services Program have declined significantly over the last three years, down a total of 27 percent (a decline of well over 35,000 CYPs per year). The first quarter data show that CYP achievement so far is running about 11 percent lower in 1998 than in 1997.

The major cause of this problem is declining acceptance of VS and IUDs. CYPs for female VS are only at 69 percent of the target. IUD insertions are at 84 percent and vasectomy (a minor method) is at 86 percent. This decline is because there are fewer patients. There are fewer patients because of three factors mentioned previously: (1) higher prices, (2) less promotion, and (3) limited transportation of clients to the clinics. USAID has recommended several times that ASHONPLAFA adopt a sliding-scale schedule for charges so that poor clients would pay less than those more able to pay. However, the team did not see any examples of sliding scales in the clinics visited. All of the prices are fixed and posted, except for sterilization. The price for sterilization is negotiated and reduced significantly for those who cannot afford to pay the full price. Some clinics seem to have a policy of not turning anyone away who requests sterilization; others seem to require a minimum payment of L 100 to 200. Prices for all services and most contraceptives vary by region to allow for differences in income and cost of living. This system, while needing some fine-tuning, seems to work well and is flexible enough, while avoiding the intrusive "means tests" and paperwork required by most sliding scales.

## Conclusions

The shared-risk system has been accepted by the physicians, and they are quite satisfied with it. The physicians make more money now than before, as does ASHONPLAFA. However, the system has not increased CYP achievement, which remains where it was in 1997, at 74 percent of the target. So far, the system has helped improve self-financing slightly, but has not helped improve CYP achievement. However, the system is very new and it would be premature to conclude that it will not have an effect in the future.

## Recommendations

ASHONPLAFA should monitor the impact of the shared-risk system on profit and loss and CYP production. Quarterly analyses of this information should be prepared for the Tegucigalpa and San Pedro Sula medical and clinical services, in particular. ASHONPLAFA staff should be apprised of these preliminary results and encouraged to counsel and educate all women who come for "diversified" services on the benefits of family planning. Shared-risk physicians should also be encouraged to do the same.

**3. Ensuring ASHONPLAFA's Focus on Family Planning: What can be done to ensure that ASHONPLAFA continues to focus on family planning while diversifying its services to increase income?**

Findings

There is some concern within USAID, but not within ASHONPLAFA, that the pressure to become self-financing could change the association into a "health business" where profit, rather than the promotion of family planning, becomes the objective.

The team found no evidence of such a change. Everyone who discussed this issue, from central managers to clinic nurses, was adamant that ASHONPLAFA is, and will remain, a social service institution, that the promotion of family planning is its mission, and that diversification of services is a necessary means to that end. As several staff put it, "we realize that family planning cannot pay for itself. Therefore, we must add other services so that we can continue to raise enough money to provide family planning to our people. That is our mission."

ASHONPLAFA's charter prohibits it from becoming a profit-making institution. Its mission limits it to health-related activities. The restriction is not so much on its sources of income as on its use of funds. Thus, it would be perfectly acceptable for ASHONPLAFA to go into the business of selling ambulances and using that profit to provide health services to the poor.

Conclusions

ASHONPLAFA has no intention of changing its mission. Also, it is restricted from changing its mission from a nonprofit, social service agency that works in the health field for the benefit of Honduran citizens to a for-project organization.

Recommendations

None.

**4. Social Marketing Achievement: In 1997, the SMP was responsible for less than 10 percent of ASHONPLAFA's total CYP achievement. Should this program be continued? Why or why not? What impact would eliminating this program have on ASHONPLAFA's total CYP achievement and self-financing goals?**

Findings

The SMP has experienced a remarkable, and positive, turnabout over the last six months. Sales began to improve around November 1997 and were strong through the first quarter of 1998. CYPs increased accordingly. Both condoms and oral contraceptives exceeded their quarterly goals by half (see Table 9). Projections made by the team are for CYPs to reach around 40,000 in

1998 compared to 14,579 in 1997. Income for the first quarter is as much as the total income for 1997 and could reach over L 6 million in 1998.

**Table 9**

**Social Marketing Program Costs, Income, and CYPs, 1995-1998**

| Social Marketing | Years | | | | Quarters | | |
|---|---|---|---|---|---|---|---|
| | 1995 | 1996 | 1997 | Increase | 1997 (1/4) | 1998 (1/4) | Increase |
| Income | 1,951,972 | 2,012,455 | 1,628,984 | -16.5% | 332,932 | 1,577,223 | 373.3% |
| Expenses | 1,786,250 | 2,082,952 | 2,335,194 | 30.7% | 253,144 | 866,775 | 242.4% |
| Profit/ (Loss) | 165,722 | (70,497) | (706,210) | -526.1% | 79,788 | 710,488 | 790.4% |
| % Self-Financed | 109.3% | 96.6% | 69.8% | | 131.5% | 182.0% | |
| CYP | 27,426 | 18,179 | 14,579 | -33.7% | 3,283 | 10,052 | 67.3% |

Note: See Appendix D, Tables D-3 and D-4 for details.

The SMP's remarkable turnaround was brought about by numerous factors, including the hiring of a professional manager, development of an effective marketing plan, improved packaging, advertising, market research, point-of-sale promotion, repositioning of the products, and better distribution. The Social Marketing for Change project's (SOMARC) technical assistance was timely and effective.

The future of the Social Marketing Program looks very bright. If the program is as successful as projected, some funds will be available to cross-subsidize the Community Services Program and, perhaps, other family planning services that are not financially self-sustaining. The SMP has already provided free packaging to the CSP and is considering introducing other non-contraceptive products, such as cytology kits, vaginal creams, pregnancy test kits, and disposable specula, that could generate additional income for cross-subsidization. A pilot test of a package of 12 basic products is about to get underway. If successful, it will be distributed nationwide.

Discussions are also underway regarding the introduction of IUDs and injectable contraceptives. The IUDs could be sold directly to pharmacies through the current distribution system, but injectables would require medical detailing, as they require a physician's prescription. Thus, the physicians would have to be "sold" on prescribing the product.[13] Nevertheless, injectables are very popular (and profitable) in many other countries and ASHONPLAFA should examine this market

[13] In reality, injectables can be purchased in almost any pharmacy without prescription.

seriously. No specific plans have been made to introduce NORPLANT®. The team believes that NORPLANT is not appropriate for Honduras and ASHONPLAFA: it is an expensive method that requires extensive and costly provider training and supervision. The latest IUDs compare favorably with NORPLANT for long-term use and are much less expensive and require far less provider training.

The principal threat to the program comes not from private sector competitors, but from USAID. USAID/Honduras donates contraceptives to the MOH for free distribution. These contraceptives are meant for low-income people who cannot afford to buy contraceptives on the open market. However, as is the case in many other countries, no screening mechanism is used and anyone, whether they can pay or not, can obtain these contraceptives free from the MOH. Although the intention is good, this practice eliminates a significant portion of the private market. For example, the total condom market in Honduras is estimated to be 7 million units per year. USAID recently donated 4 million condoms to the MOH, which effectively reduces the private market to 3 million.

The other threat is from the USAID Regional Office in Guatemala, which is pressing ASHONPLAFA to distribute "VIVE," a condom designed to attack the spread of HIV/AIDS. Although it is well intentioned, this condom could destroy ASHONPLAFA's condom market, which would, in turn threaten the cross-subsidization of community and medical family planning services. (See Appendix A, question 2 for further discussion of this threat.)

Conclusions

The SMP is now doing very well, both in terms of CYP achievement and in generating income that can be used to cross-subsidize essential family planning services. The SMP could account for as much as 25 percent of ASHONPLAFA's CYPs and income this year. It also has the potential for further expansion as new products are introduced. The principal threats come from USAID itself, through well-intentioned, but competitive, programs.

Recommendations

The SMP should be continued, and should remain exactly where it is organizationally within ASHONPLAFA, as a companion to other sales efforts and the CSP. Cross-subsidization of that program is made easier by this organizational link, and the team recommends that it be maintained. Further development of the SMP should continue with the planned introduction of IUDs; non-family planning products; and possibly, injectable contraceptives. Every effort should be made to eliminate, or at least minimize, the unintentional competition from other USAID-funded programs.

**5. Community Services Achievement: ASHONPLAFA's CSP has been functioning relatively well over the past five years, producing about one-third of ASHONPLAFA's total CYP achievement in 1997. However, what can**

**USAID/Honduras do to help improve this program to increase the prevalence of contraceptive use in rural areas without sacrificing self-sufficiency?**

The CSP sells unbranded condoms and pills to local vendors who run "Family Planning Posts" in rural and periurban areas. This program is different from the SMP, which sells branded pills and condoms to pharmacies in urban areas. The two programs are separate organizationally, although they are both located in the Sales Division. The CSP uses male "promoters" to distribute contraceptives to the posts, collect money, and provide supervision. Usually one, two, or three of these promoters work in each region depending on the number of posts. The CSP also has female "reproductive health promoters" who are supposed to provide reproductive health education and information to individuals and groups throughout their region. They work in both rural and urban areas, visiting potential family planning candidates in maternity wards, meeting with women's groups, and helping with education and counseling in the regional clinics. In some regions, the two promoter functions have been combined as a cost-saving measure.

Findings

As indicated in Table 10, the CSP has had fairly steady CYP achievement since 1995, averaging around 48,000 over the past two years. However, the first quarter results are down and the evaluation team projection is only about 36,000 CYPs for 1998, which is 71 percent of the goal. Oral contraceptives are the major CSP method, making up 90 percent of the CYPs. Thus, the decline in oral contraceptive sales account for most of the problem. Condom sales are also down, however.

Sterilization data are reported in the Medical/Clinical Services Program, but referrals from CSP promoters have been an important contributor to the number of sterilizations performed each year. The team learned in its field visits that sterilization referrals have decreased and the lack of transportation to bring clients to VS clinics has also affected the number of procedures performed each month.

**Table 10**

**Community Services Program Costs, Income, and CYPs, 1995-1998**

| Community Services | Years | | | Increase (%) | Quarters | | Increase |
|---|---|---|---|---|---|---|---|
| | 1995 | 1996 | 1997 | | 1997 (1/4) | 1998 (1/4) | |
| Income | 2,841,136 | 3,931,650 | 5,039,835 | 77.4 | 1,356,558 | 1,300,156 | -4.2% |
| Expenses | 4,298,197 | 4,380,239 | 4,433,417 | 3.1 | 770,894 | 970,839 | 26.0% |
| Profit/(Loss) | (1,457,061) | (448,589) | 606,418 | 141.6 | 585,664 | 329,317 | -43.8% |
| Percent Self-Financing | 66.1% | 89.8% | 113.7% | | 176.0% | 133.9% | |
| CYP | 50,695 | 47,844 | 48,842 | 3.7 | 8,464 | 9,052 | 6.9% |

Note: See Appendix D, Tables D-7 and D-8 for details.

The CSP seems to be experiencing much of the consequences of cost cutting. Close to 500 posts have been closed (around 25 percent), the number of promoters has been reduced in many regions, promoters have been assigned part-time to clinics to do administrative work, transportation to bring promoters to rural areas and to bring clients to the clinics has been severely curtailed, vehicles are in short supply, and promotional material and equipment are sorely lacking.

The biggest gap in the program seems to be in promotion and transportation. Almost all regions (outside of Tegucigalpa) lack an adequate number of vehicles. As an example, a minivan used for community services in San Pedro Sula was stolen last year and no plans have been made to replace it. That leaves San Pedro Sula with one vehicle for the entire region.[14] Juticalpa also has only one vehicle, which is used almost exclusively by the sales promoter. Another vehicle was sent to Tegucigalpa for repairs months ago and was never sent back. Most of the reproductive health promoters do not have access to any vehicle, except when a sales promoter has time to help out. ASHONPLAFA's medical services budget includes funds from USAID to purchase five vehicles this year for Olancho, Copán, and one other region. Those funds will be complemented with medical equipment, some of which is to be used for the Rural Brigades that travel to rural areas to provide family planning and reproductive health services.

Most of the promoters said that they also need loudspeakers, or *autoparlantes*, so that they can broadcast information and educational messages around town and in the communities they visit. They also need cassette tapes and players, as well as leaflets and handouts to distribute.

[14] The inventory shows four vehicles at SPS, but the one van was stolen and two other vehicles are unusable.

Conclusions

Although the CSP is the major vehicle for extending coverage in rural areas, it does not have the resources it needs to maintain current coverage, much less to extend it. Significant cuts have been made to costs, but as a result the ability of the program to achieve its family planning and reproductive health objectives has been limited. The greatest needs are for vehicles and promotional equipment, supplies, and literature. Because ASHONPLAFA is trying to become financially self-sufficient at the same time as it is trying to expand coverage, special funding will be required. Funds could be taken out of current savings, because ASHONPLAFA is well ahead of its self-financing goal. Special requests could be made to the Japanese or other donors that specialize in providing equipment. Local fund-raising campaigns could be conducted to secure the needed money.

Recommendations

If increasing contraceptive prevalence in rural areas is really a priority, ASHONPLAFA will need to invest in promotion and services for the rural poor. Vehicles and promotional equipment should be provided to reproductive health promoters so they can visit rural areas and carry out their education and information activities. Arrangements also need to be made to either bring family planning and reproductive health services to the communities or to bring clients to the clinics. Alternative sources of funding should be identified and explored.

**6. Grants to PVOs versus ASHONPLAFA to Expand Rural Family Planning: In an effort to expand private sector family planning services in rural Honduras, in 1997 USAID awarded grants to ASCH and PRODIM, two local PVOs. USAID is planning to award two more grants in 1998. In terms of coverage and efficiency, does it make sense to award grants to two more PVOs, or would it be better to grant the money to ASHONPLAFA to expand its rural family planning services?**

Findings

Both ASCH and PRODIM are small PVOs that specialize in general development activities that they carry out in small geographic areas. Both have collaborated with ASHONPLAFA on an informal basis, especially where both agencies have ongoing activities, such as in Comayagua, La Paz, and Lempira. PRODIM, for example, provides health services for children under age five, nutrition services, and reproductive health services for women, including family planning. The two agencies collaborate in providing information and education to women in the community. PRODIM refers women to the MOH and ASHONPLAFA for clinical services, especially sterilization, and in some cases provides or pays for their transportation to and from the clinics.

The major limitation with most PVOs is that their coverage potential is usually limited because they work in small geographic areas. PRODIM and ASCH, for example, are working in four principal areas: La Paz, Comayagua, Intibucá, and Sabanagrande. ASHONPLAFA covers the

nation. The major advantage of PVOs is that they tend to saturate the areas they work in and provide a broad range of services. ASHONPLAFA, on the other hand, has a limited presence in each area and specializes in family planning and reproductive health care.

Costs and productivity are difficult to compare because each type of organization provides different services to different populations. One cannot compare the cost per CYP of PRODIM providing education, health, and economic development services to 200,000 people in La Paz with the cost per CYP of ASHONPLAFA providing family planning services to 100,000 people in Comayagua. The best way to make such comparisons would be to solicit proposals from ASHONPLAFA and qualified PVOs to provide the same services to the same population. For example, what would it cost ASCH, PRODIM, and ASHONPLAFA to provide complete reproductive health services to a population of 200,000 in La Paz?

Perhaps the best strategy would be to combine the strengths of each organization with the infrastructure of the MOH to expand services to the more populated rural areas. The areas selected by PRODIM and ASCH fit into that strategy. Together, they will cover a population of 460,000 in 62 municipalities with 148 service delivery points. This is a significant area in terms of potential coverage—approximately 11 percent of the entire rural population of Honduras.

USAID is about to award grants to two more PVOs. If those PVOs also concentrate on densely populated rural areas, coverage could be significantly expanded. Intensive promotion, education, and referral by the PVOs, coupled with contraceptive sales and clinical services from ASHONPLAFA, together with training of MOH nurses and doctors and use of MOH facilities throughout the area could expand coverage more efficiently than a competitive strategy where each organization operates independently.

Conclusions

The number of PVOs in Honduras that do, or could, provide family planning and reproductive health services in rural areas is small in terms of both numbers and coverage potential. But, those PVOs also tend to provide intensive services in the areas they do cover. ASHONPLAFA, on the other hand, already has the infrastructure and national network, but its presence and resources are limited. A combination, or partnership, could be more effective and efficient than choosing one over the other.

Recommendations

USAID should structure the PVO grants to optimize collaboration among the PVOs, ASHONPLAFA, and the MOH so that each contributes what it does best in providing family planning services to the PVO target population.

## 7. PRODIM and Save the Children Coordination with ASHONPLAFA: How well are PRODIM and Save the Children working with ASHONPLAFA?

Findings

As noted in the previous question, both PRODIM and ASCH collaborate with ASHONPLAFA, especially in the field. However, this collaboration is largely informal. Neither program has a formal agreement with ASHONPLAFA, nor do they have joint projects. Nevertheless, they work together to support and complement one another's activities. PRODIM has called upon ASHONPLAFA to assist in their training programs and to provide training to their staff.

Conclusions

As far as the evaluation team can tell, PRODIM and ASCH are on good terms with ASHONPLAFA and collaborate on an informal basis as needs arise.

Recommendations

None.

# 5. SUPPORT SYSTEMS

## 5.1 Overview of Findings

In addition to the two major questions on sustainability and CYP achievement, USAID also had concerns about some of ASHONPLAFA's support systems that it has spent a good deal of time and money trying to strengthen. The areas of primary concern are the information systems: cost accounting, service statistics, clinic administration, inventory control, research studies, and evaluations. Human resources is a critical support area during this transition period. Future technical assistance needs, if any, are also a concern because funds are limited. This chapter addresses these concerns and a proposal by a regional HIV/AIDS program to involve ASHONPLAFA in the distribution of its condom.

## 5.2 Questions and Responses

### 1. Management Information, Research, and Evaluation: To what extent have the management information, research, and evaluation systems been implemented and to what extent have the data generated by these systems been effectively used in planning and decision making? How can these systems and their use be further strengthened?

According to the project agreement, by the end of the project the MIS is to "present accurate and relevant information on finance, service utilization, and quality, and...data [to] be used for decision making." The MIS is to be computerized and will include (1) a clinic administration system (SAC), (2) a cost control system (SCC), (3) a Services Information and Statistics System (SIES), and (4) an Inventory Control System (SCI). The MIS was to be fully functional in all five regions and at headquarters by the end of 1996.

The Research, Evaluation, and Monitoring systems were also to be upgraded and streamlined by the end of 1996. The objectives were to provide complete service and programmatic statistics in a timely, accurate, standardized manner so that those statistics would be widely used. Research and evaluation results were to be timely and accurate and used for decision making and program modification. A large amount of technical assistance was to be provided to ASHONPLAFA by the Population Council, the Quality Assurance Project, Management Sciences for Health/Family Planning Management Development (MSH/FPMD), SOMARC, and Population Communication Services (PCS). Training and technical assistance in the use of this information was also to be provided.

Findings

As noted previously, the corporate culture has changed remarkably in response to the reorganization and emphasis on self-financing and CYP achievement. As a result, the use of all statistical, research, and evaluation reports has increased tremendously. Where such reports were largely ignored in the past, they are now at the fingertips of all central and regional managers.

The statistical reports have become one of the most used information tools in the association. Set up in a simple, standardized format to show results compared to quarterly and annual goals, managers can easily tell exactly where they are in terms of CYP achievement (see examples in Appendix D-8 and D-9). Other reports summarize costs, income and self-financing achievement (see Appendix D-4). Good achievement generates pride among the staff members, and underachievement motivates staff to work harder to improve performance. The data are analyzed extensively at the central level to identify trends, make projections, identify causes of problems, and take action to make corrections.

The research and evaluation reports have also been well used extensively. Several of them have been identified in this report. As noted in Chapter 3, a cost study was conducted to determine what each service actually costs and then used to reset prices and compensation payments for physicians. These two initiatives (increased prices and the "shared-risk" system for physicians) came directly as a result of the cost study and resulted in significant cuts in operating costs and in income.

Client exit interviews have been used to assess client satisfaction and to take action to improve clinic operations. For example, waiting time has been reduced, clinic hours extended in some areas to five o'clock in the evening, clinics opened on Saturday mornings in some areas, additional services have been added, refreshment vending machines set up in waiting rooms, price boards set up, and privacy improved.

Evaluations of key interventions, such as the internal image campaign, were conducted to assess impact and to make adjustments. Market research has been conducted to identify target markets and their preferences and to test messages, packaging, and pricing.

The chief of the Research, Evaluation and Statistics Division remarked that three years ago no one used their reports, but now everyone uses them. Such use was verified by the team's field operations, which found that even the nurses who run the satellite clinics monitored their statistical reports closely and had used the results of such studies as client views on quality of care to improve their clinics.

This is not to say that there are no problems. The chief of Administration and Finance pointed out that they have found problems with several of their computer programs. The cost-accounting program, for example, cannot accept as many digits as are needed for the cost codes, the inventory program is not ready for the change to the year 2000, and the same program does not

allow totals to be calculated for some columns. The division plans to install a new general accounting program soon (MBA*CASE) and is looking into other software to replace the SCI.

All of the computerized systems are not yet installed in all regions. For example, SAC is installed everywhere but Juticalpa. The plan to connect all of the regions with the central computer is expected to be tested this month. When the network is fully functional and the regional staff trained, there should be a significant reduction in form filling and a considerable increase in productivity. For example, purchasing requests, budget revisions, cytology exam results, and patient information will all be able to be processed electronically. This innovation should result in a reduction of central staff.

Conclusions

Management information, research, and evaluation reports are now seen as valuable tools by ASHONPLAFA managers at all levels. They are definitely used for planning, monitoring, and other forms of decision making.

Recommendations

ASHONPLAFA should continue to improve and streamline its various management information systems. Training in advanced data for decision making should be provided to all regional and central managers.

**2. HIV/AIDS Condom Distribution: ASHONPLAFA has been approached by the USAID regional HIV/AIDS condom Social Marketing Program (Pan American Social Marketing Program [PASMO]) to collaborate in the distribution of the regional project's "VIVE" condom. Would it make sense for ASHONPLAFA to collaborate with PASMO? If not, is it feasible for ASHONPLAFA to market an HIV/AIDS condom of its own in Honduras? Could ASHONPLAFA achieve the national coverage that would be needed to reduce the transmission of HIV in high-risk groups and in the general population? Would other donors be interested in supporting ASHONPLAFA in marketing an HIV/AIDS condom?**

Findings

ASHONPLAFA and the MOH (with significant support and investment from USAID) have already developed a "product line" for the condom market that is nationwide. The condoms are as follows:

- PIEL, a new, high-end condom that has just been launched (priced at L 18 per pack of three);
- Guardian, a well-known, low-end condom that is about to be relaunched,

(L 6.5 pack of three);

- A "No-Logo" condom that is priced lower than VIVE (L 0.80 per condom); and
- Free condoms distributed by the MOH.

The VIVE condom is a lower-priced branded condom in direct competition with Guardian. The following conditions apply to its distribution:

- Directed at the same market segments (C and D) as ASHONPLAFA's Guardian condom;
- Positioned as a general condom that provides protection, and not as an AIDS condom;
- To be marketed in the same urban markets as Guardian, it will not expand coverage to rural areas;
- Priced significantly lower than Guardian (L 2.75 for a box of three);
- Not distinguishable from Guardian except for the price.

VIVE poses a significant threat to the sustainability of ASHONPLAFA's family planning program for the following reasons:

- The Honduran market for condoms is estimated to be about 7 million per year. The MOH provides 4 million free condoms per year, thus reducing the private market to 3 million;
- Guardian, which may reach 1.2 million units in 1998, requires sales of 800,000 per year to break even and stay viable;
- VIVE would significantly reduce Guardian's market, which would threaten its existence;
- Cross-subsidization of ASHONPLAFA's rural family planning program would be severely reduced; and
- VIVE would jeopardize ASHONPLAFA's sustainability progress, which would jeopardize its ability to provide comprehensive reproductive health services nationwide.

VIVE is not a sustainable product for the following reasons:

- PASMO has acknowledged that VIVE will never be self-sustaining. It is to be cross-subsidized from sales of a selection of ancillary products, such as vitamins, oral rehydration salts, and Pap smear kits. These products will also be competing with ASHONPLAFA's product package, which is also designed to generate funds to cross-subsidize other family planning services.

- By the time USAID/Guatemala support for VIVE ends in two years, it is unlikely that VIVE will be self-financing in Honduras. Thus, there is a good chance that Honduras will be left without VIVE or Guardian when the project ends.

ASHONPLAFA believes it is being pressured to accept VIVE against its best interests. It does not see any advantage in accepting PASMO's proposal for the following reasons:

- The threat to the sustainability of ASHONPLAFA's services will not be made up by the distribution fees to be realized from VIVE; and

- ASHONPLAFA believes that it should not be placed in the middle of a debate between two USAID offices, but should be free to make its own decision regarding VIVE.

ASHONPLAFA recognizes the importance of a strong and effective HIV/AIDS program. It is willing to participate in such a campaign, provided the campaign does not jeopardize ASHONPLAFA's own Social Marketing Program. The following are some of ASHONPLAFA's key concerns:

- If VIVE is brought in to Honduras, it should not be priced lower than Guardian;

- Money raised for cross-subsidization in Honduras should remain in Honduras to cross-subsidize family planning and HIV/AIDS promotion and services;

- VIVE distribution should be limited to HIV/AIDS-related outlets, such as brothels or gay bars;

- Any HIV/AIDS campaign should not compromise ASHONPLAFA's efforts to provide essential reproductive health and family planning services;

- The VIVE campaign should focus on public education regarding HIV/AIDS and promote the use of condoms in general to prevent AIDS;

- Any HIV/AIDS campaign should build on the infrastructure already developed by ASHONPLAFA, the Ministry of Health, and CAs and neither duplicate nor replace that infrastructure; and

- Any support for HIV/AIDS promotion and services should be integrated into and strengthen ongoing promotion and service activities.

ASHONPLAFA is capable of promoting Guardian for HIV/AIDS prevention. It would need support (and technical assistance) to mount an HIV/AIDS promotional campaign. It does not need another low-end condom. It would be interested in collaborating if PASMO would be willing to fund such a campaign with Guardian as the condom.

Conclusions

There is no need for USAID/Guatemala to introduce another condom in Honduras. The VIVE condom would "cannibalize" the ASHONPLAFA market, because it would be a lower-priced, branded condom in direct competition with Guardian. VIVE poses a significant threat to the sustainability of ASHONPLAFA's family planning program. VIVE is not a sustainable product. Once USAID support ends for VIVE, Honduras could easily be left with neither VIVE nor Guardian. ASHONPLAFA is being pressured to accept VIVE against its best interests. It does not see any advantage in accepting PASMO's proposal.

Recommendations

The team is unanimous in recommending that ASHONPLAFA not collaborate with PASMO in distributing the VIVE condom. ASHONPLAFA and PASMO should explore a cooperative arrangement whereby PASMO would invest its resources in promoting the use of condoms in general to prevent the spread of HIV/AIDS, rather than in the promotion and distribution of VIVE as an all-purpose condom. ASHONPLAFA would join in this campaign by expanding distribution of Guardian and non-logo condoms to high-risk groups and in areas where HIV/AIDS is highest. ASHONPLAFA would also promote HIV/AIDS education in its clinics and community programs. This strategy would result in an aggressive campaign to attack HIV/AIDS while preserving ASHONPLAFA's cross-subsidization of essential family planning services in rural areas.

**3. Technical Assistance Needs: During the last two years, ASHONPLAFA has received a substantial amount of technical assistance from USAID-supported Cooperating Agencies (CA). Mission population funds, however, are becoming scarce. Thus, the Mission is not in a position to provide the same level of technical assistance to ASHONPLAFA in future years. In order of priority, which programmatic, administrative, and managerial areas in ASHONPLAFA need to continue to receive technical assistance?**

Findings

SOMARC's technical assistance contract ends in September 1998, and it believes that no further assistance will be needed in social marketing unless a new line of products is launched (for HIV/AIDS, for example).

ASHONPLAFA would also need technical assistance if it adds maternity (or birthing) services, because this will require different organizational and staffing patterns. As noted, the team believes that ASHONPLAFA will require technical assistance if it expands to include HIV/AIDS as an educational or service program.

ASHONPLAFA has received a good deal of assistance in developing its new strategy. The executive director, for example, is currently attending an MSH workshop on sustainability; the sales chief is attending a SOMARC course on social marketing; and various other staff have attended related training in management, cost-effectiveness, and quality assurance. Furthermore, the Human Resources Division can now handle internal training of ASHONPLAFA staff in many of these topics. For example, 1998 workshops include cost accounting, data for decision making, and social marketing. Further technical assistance in these and related areas may be needed only for advanced level courses, especially in sustainability and strategic planning.

MSH has provided considerable technical assistance in managing human resources. Such technical assistance will undoubtedly be needed over the next half of the project. In addition to such technical areas as cost-accounting and incentive systems, organizational dynamics is likely to be an area where a good deal of help may be needed as ASHONPLAFA continues to downsize and make changes in its structure, functions, and personnel. Decentralization is an area that will need serious attention.

One of the most critical areas of effort for ASHONPLAFA will be the expansion of family planning and reproductive health services in rural areas. Cost cutting has taken its toll on services and innovative technical assistance will be critically needed to identify alternative approaches to rural services.

Conclusions

ASHONPLAFA's need for quality technical assistance is likely to continue to be high over the next several years. USAID is the only donor agency that is able to provide this type of assistance over a broad range of subject areas. The priority areas are likely to be human resources management, and expansion of services to rural areas, sustainability (of outcomes, not inputs), decentralization (of authority, not just responsibility), HIV/AIDS promotion and services, and maternity and birthing services. There should be no technical assistance needed in such well-developed areas as accounting, finance, information systems, research, or evaluation.

Recommendations

ASHONPLAFA should develop or update its strategic plan to reflect its sustainability objectives with respect to decentralization, expansion of services to rural areas, inclusion of HIV/AIDS and maternity services, and staffing patterns. Based on that plan, ASHONPLAFA should identify technical assistance needed to implement that strategic plan.

**4. The Reproductive Health Working Group: The Private Sector Population III Project had called for three reproductive health committees (training, services, and IEC). As things have evolved, there is just one reproductive health working group, organized by the Population Council. How effective is this working group?**

Findings

The objective of the working group is to contribute to the search for strategies to improve the reproductive health of Honduran families. It is an informal group of about 25 members representing government agencies (MOH, IHSS, Ministry of Education), donor agencies (PAHO, UNFPA, GTZ, and USAID), and private nongovernment organizations (ASHONPLAFA, PRODIM, ASCH, Project Hope, and Foster Parents Plan International [PLAN]). The group meets monthly to exchange experiences, information, and materials; to coordinate plans, and to learn from one another. Experts give presentations at each meeting and discuss ideas for expanding and improving services.

The group was brought together initially by the Population Council, but starting this year the local members rotate responsibility for the agenda, venue, speakers, and other logistical arrangements. The group has no funds, no formal organization, and no authority. Nevertheless, it is an excellent forum for exchanging information that is then disseminated by participants to their own staff. The few people that the team had time to interview about the working group believe that it is a very valuable and inexpensive way to share information and coordinate activities. Those members of the team who had participated in similar groups agree.

Conclusions

The Human Reproduction Working Group is an inexpensive and effective mechanism that provides a forum for sharing useful information and coordinating activities.

Recommendations

None, except to encourage the group to continue what it is doing.

## 5. Human Resources: How well are efforts in this area contributing to sustainability?

By the end of the project, ASHONPLAFA was to be appropriately and sustainably staffed to achieve project results, and all personnel were to be motivated and capable of achieving institutional goals. In Year 1, the Human Resources Division (HRD) was to assess staffing levels, personnel qualifications, and performance in relation to planned results. Staff were to write semiannual performance evaluations and providers were to include a maximum and minimum productivity target. Key management staff were to establish self-sufficiency targets for their departments, and an institution-wide incentive plan was to be developed. All staff were to receive raises based on achievement of their goals. "Right-sizing" of staffing patterns was to be undertaken, and a substantial amount of training and reorientation was to be undertaken in quality assurance, social marketing community services counseling, strategic planning, MIS and use of data for decision making, and contraceptive logistics.

Findings

ASHONPLAFA's personnel are going through a classic "downsizing" and organizational transition where uncertainty, rumors, sadness, frustration, anger, and a sense of powerlessness are common. The payroll has been reduced from 280 in 1995 to 219 at the time of this writing, a reduction of 67 positions; 60 of those reductions were forced. Such reductions in staff always bring stress with them—less on those who leave than on those who remain. A dozen senior and mid-level staff were interviewed and asked "how far along the transition curve do you think ASHONPLAFA has come?" Most of the respondents answered "about two-thirds of the way." When questioned further, most admitted that the organization is suffering through all of the symptoms described in the downsizing literature. The old expectation of lifetime employment for loyal employees has disappeared in ASHONPLAFA, and the new psychological contract is not yet firmly in place.

ASHONPLAFA leaders have taken numerous positive steps to combat this well-documented "survivor sickness." A series of workshops and meetings were held for all staff last year entitled "The Internal Campaign." The workshops were held over several months, and most interviewees expressed appreciation for what they took away from these events, where feelings surrounding the downsizing and transformation were aired, and the "hurt" accepted. Downsizing literature is unequivocal that this is an essential first step forward combating survivor sickness.

More tangibly, numerous organizational manuals have been produced in the last six months: a *Manual de Capacitación* in October; a *Manual de Entrenamiento* at the end of the year; and a *Manual de Organización y Descripción de Funciones*, in December. A *Manual de Administración* is in the late stages of development. These manuals are important because they formalize the restructuring of the institution and the reorganization of authority and responsibility. They symbolize a tangible break from the past and a psychological confirmation that the organization is moving forward.

Numerous other human resource elements are now in place. The HR Division has conducted a department-by-department staff assessment and is preparing training plans based on individual department priorities. Semiannual evaluations are now being conducted, with career growth planning an integral part of the instrument. An organizational climate study is about to be conducted. An incentive plan for staff has been developed and is being implemented. HR training is advancing nicely in accomplishing its 1998 targets, and workshops have been held or are planned on quality assurance, social marketing, cost accounting, and use of data for decision making.

It appears that over the recent past, ASHONPLAFA has received a great deal of high-quality technical assistance from Management Science for Health (MSH) to help guide them in the area of human resources management. Although the evaluators were not able to speak to any of the MSH consultants involved in this process, the impact on ASHONPLAFA can be seen in its actions.

## Conclusions

ASHONPLAFA is handling the organizational transition in an honest, straightforward, and sensitive manner. Not everyone is happy with the transition, but most understand, accept, and support it. The short-term effects on financial self-sufficiency are already visible, and this is a source of staff satisfaction.

## Recommendations

ASHONPLAFA should continue its organizational transition through to its conclusion. Management openness, communication, feedback, and encouragement also need to be continued. The technical assistance provided by MSH in this area should also be continued. ASHONPLAFA may wish to consider hiring a "downsizing" expert to conduct a workshop to help staff deal with "survivor syndrome" and replicating the internal climate study to assess progress and identify adjustments that need to be made.

# 6. LESSONS LEARNED

We define "lessons learned" as generalizations that are likely to apply to similar programs and projects. In most cases, they describe causal relationships—if *x* occurs, then *y* will usually result. They are intended to guide future strategic planning, but may also be useful for day-to-day operations.

## 1. "Financial self-sufficiency" and increases in "CYP achievement" are mutually incompatible objectives.

As one senior official at ASHONPLAFA summarized, "This is a reality that USAID seems to accept but ignores anyway." IPPF made this point formally in 1995, and USAID responded by saying that financial self-sufficiency would be the primary objective for the first year.[15] Three years later, financial self-sufficiency remains the priority, but so does maintaining CYPs. The CPR objective for 2000 has not changed, which will require increasing—not just maintaining—CYPs over the next two years.[16] Since the CYP is an interim "proxy" for CPR, it seems inconsistent to have a goal to maintain the one while increasing the other.

The evaluation SOW says that "A decision was made in 1996 that ASHONPLAFA's principal goal is to reach self-sufficiency in the shortest time possible...plans to expand services, in an attempt to increase CYPs, were put on the back burner." Yet, one of the recommendations of the Results Package team in November 1997 was "that USAID/Honduras meet with the new executive director of ASHONPLAFA and the Board of Directors to stress the importance of achieving CYP goals." At the Mission review of the ARR, it was decided that "the mission should not lower ASHONPLAFA's CYP target [i.e., maintenance of 1995 level]. It is necessary to keep ASHONPLAFA aware that this should be its ultimate goal."[17]

While encouraging more effort to improve self-sufficiency, USAID also wants to see CYPs maintained—an impossible goal, at least in the short term. ASHONPLAFA has been concentrating on self-financing. The predictable effect on CYP achievement has occurred. ASHONPLAFA has done a remarkable job of cutting costs and increasing income, but at a price: the reduction of services and coverage, which translates into fewer CYPs. If ASHONPLAFA tries to expand coverage in rural areas, as this evaluation recommends, such expansion will come at the

[15] Letter to Mary Ann Anderson from Marcia Townsend, September 22, 1995. Memo from Mary Ann Anderson to Marcia Townsend, October 13, 1995.

[16] Project objectives call for ASHONPLAFA CYPs to remain at 207,495 (the 1995 achievement level) through 2000, then to increase to 217,869 in 2001; 228,762 in 2002; and 240,200 in 2003—increases of 5 percent annually.

[17] SO3 1997 Annual Results Review (ARR) and Issues. November 21, 1997.

cost of financial self-sufficiency. It should be clear that expansion of services in rural and remote areas will cost more than expansion in urban areas. The marginal cost of each additional CYP is likely to increase with each kilometer of expansion. It is not just a question of distance, but of cultural resistance and ignorance. The easy part is over. Now comes the hard part. USAID must decide which is more important: financial self-sufficiency or contraceptive prevalence.

**2. If the objective is to affect inputs, then outcomes will be of secondary concern.**

Self-financing focuses on inputs—the lowering of costs and the raising of revenues. There is nothing wrong with that in the business world. But, in the social sector the emphasis is supposed to be on outcomes—for example, improving health and reducing fertility. When the emphasis is placed on inputs instead, what happens to the outcomes is of secondary interest. This can be seen in ASHONPLAFA's cost cutting in the rural CSP. Savings have been made, but at the price of reduced services, promotion, and transportation of clients to family planning clinics. If the emphasis were on sustainability of services, rather than on self-financing, the objective would be to preserve the outcomes by finding alternative ways to finance them.

**3. Diversification of services will increase income, but not necessarily contraceptive prevalence (or CYPs).**

The ASHONPLAFA experience clearly demonstrates this lesson. All of the health services that were added to enhance the self-financing goal made a profit. That profit is important, not just for self-financing, but for cross-subsidization of family planning services. But, none of these services raised CYPs in and of themselves. They may have presented an opportunity to inform non-family planning users of the benefits of adopting a method, but even that is not guaranteed. As ASHONPLAFA learned, the staff must be assertive and take advantage of these opportunities.

**4. Middle-class clients can be attracted to family planning clinics.**

ASHONPLAFA's experience shows that middle-class clients can be attracted if the services offered are (1) in demand and (2) better and less expensive than those of other private providers in the area. It is not enough to offer the best family planning services. A broader array of reproductive health services will attract more clients. The facilities do not have to measure up to North American standards to attract middle-class clients; they simply have to be better than those of other competitors.

**5. Competing political objectives among donors can damage a program.**

The most current example of this is occurring in Honduras, as the USAID Regional Office in Guatemala attempts to pressure ASHONPLAFA to distribute the VIVE condom to complete a regional strategy to fight the spread of HIV/AIDS. Unfortunately, this objective will jeopardize the self-financing objective that USAID/Honduras wants ASHONPLAFA to pursue. Not only is ASHONPLAFA caught in the middle, but it could be a lose-lose situation for ASHONPLAFA if the USAID offices in Guatemala and Honduras find a win-win compromise for themselves.

**6. When managers are seen to make decisions based on data and reason, staff demand for and use of data will increase.**

One of the most significant changes in the corporate culture at ASHONPLAFA is the sudden value ASHONPLAFA staff put on information. The MIS research and evaluation reports are now read, discussed, and acted upon. That change is largely due to the use of this data by top management to make financial decisions. The prime targets are inefficiency and low productivity. Staff are aware of this; to stay one step ahead of the decision makers, they are using the data themselves to increase their own efficiency and productivity.

**7. Economic incentives can be effective motivators, even in nonprofit organizations.**

It used to be considered sacrilegious to think about making money in a nonprofit organization. Those days are gone. ASHONPLAFA is clearly trying to make a profit on every service it offers, and it is offering economic incentives to its staff to encourage them to work toward this goal. The profit motive is justified, not rationalized, by the end use to which it is put—cross-subsidization of essential family planning services that cannot pay for themselves. The staff incentives are also justified, not rationalized, as a proven method for increasing ASHONPLAFA's income. By providing economic incentives to physicians and promoters alike, caseload and sales both increase, and that benefits ASHONPLAFA as well as the staff.

**8. Reducing costs is not as important as increasing profits.**

The data on income and expenses show why one should not focus solely on cutting costs or generating income. Services that are costly may actually bring in more income than services that are not expensive. The most costly family planning service at ASHONPLAFA is the CSP (over L 4.7 million in 1997); but it also has the highest income (L 5 million in 1997). By reducing such activities as promotion, rural brigades, and transportation for clients, ASHONPLAFA has successfully reduced costs. But that reduction has also reduced income. What is important is how much of a profit or loss a service makes. The CSP is one of only three family planning components that made a profit for ASHONPLAFA in 1997. Three other components lost money

for ASHONPLAFA. Thus, in searching for ways to become self-sufficient, the question should not be "How can we cut costs?" but "How can we increase profits?"

# 7. FUTURE DIRECTIONS

## 7.1 Funding Mechanisms for a Follow-On Project

USAID and ASHONPLAFA expect that there will be a follow-on project if USAID still has money for Honduras and if ASHONPLAFA does well in achieving a reasonable level of financial self-sufficiency in PSP III. USAID also recognizes that it would be a "major success" for ASHONPLAFA to reach the goal of 63 percent self-sufficiency, the "maximum level that could reasonably be expected of a family planning association in the Latin American context."[18] For ASHONPLAFA to continue providing reproductive health services, further donor assistance for the remaining 27 percent would be required. The rural outreach services, in particular, would need to be subsidized, as they "simply cannot be made financially sustainable." The team completely agrees with this statement.

Two funding mechanisms were proposed for the follow-on project: an endowment, and further project assistance.

The team would like to suggest another possibility: relieve ASHONPLAFA of the rural burden and let it concentrate on providing comprehensive reproductive health services in its urban clinics together with its Social Marketing Program, which is also urban in nature. The rural component (currently the Community Services Program) could be spun off as a separate ASHONPLAFA project or as a separate association (for example, ASHONPLAFA Rural Reproductive Health Services). The team believes that ASHONPLAFA could become completely self-sustaining under this strategy. If not, the association might require a small grant for a few more years or a small endowment to make up the deficit. ASHONPLAFA is demonstrating that it has the capability to offer diversified services to attract a clientele that is willing and able to pay for services, and to adopt a business-like, customer-oriented approach to its operations. ASHONPLAFA would continue to expand as urbanization expands and the economy grows.

To assist ASHONPLAFA in this transition to complete independence, USAID needs to adopt a hands-off management style. The association needs to learn how to make its own decisions, to take responsibility for its actions, and to take care of itself. It can only do that if it is given more autonomy. In the time remaining in PSP III, USAID can reduce the benchmarks to a minimum (three to four), limit reporting (quarterly or semiannually), minimize concurrence and approval requirements, and in other ways reduce its own management burden. The "hands-off" approach that is supposed to be applied in cooperative agreements and grants should be put into practice.

The follow-on grant, if needed, should be designed with maximum independence in mind. A true grant or endowment (with no strings), or, at most, a performance-based grant, should be the type of funding mechanism recommended.

[18] "Project Paper, PSP III," p. 48.

## 7.2 A Proposed Strategy for Increasing Contraceptive Prevalence in Rural Areas

The principal challenge identified by the team is the expansion of family planning and reproductive health services in rural areas. USAID asked the team "what it should do over the next 5 years to increase rural contraceptive prevalence by at least 10 percentage points." The following is a suggested strategy that builds on the strengths of ASHONPLAFA, the MOH, and selected PVOs.

It seems clear that none of these organizations can achieve this objective by itself. However, working together in a complementary (not competitive or independent) manner they could increase rural prevalence significantly. The MOH has the infrastructure in its CESAR, CESAMO, and hospital network, but it lacks trained personnel, equipment, and supplies. The MOH also lacks a community outreach capability. The PVOs can provide intensive promotion in the geographic areas where they work and also assist ASHONPLAFA in training MOH auxiliary nurses and physicians in reproductive health skills. ASHONPLAFA can continue to sell condoms and pills through its family planning posts (*Puestos de Planificación Familiar*) in areas where the PVOs are not working. They can also continue to do promotional work in those areas and conduct rural brigades to bring services to the larger rural communities.

ASHONPLAFA can also contribute expertise in other support areas, including research, finance, quality assurance, counseling, information systems, and IEC. The PVOs and ASHONPLAFA can combine resources to provide services through mobile clinics or through rural brigades. Sterilization candidates can be referred (and transported) by the PVOs and ASHONPLAFA to MOH and ASHONPLAFA clinics.

Donor support will be needed for at least 10 years, but should be geared toward gradual absorption of responsibility for rural services by the MOH. USAID could contribute commodities, vehicles, and clinical equipment, as well as support for training, IEC, promotion, and research. The UNFPA could also make a significant contribution to provider training, including training of trainers, provision of training materials, and support for training of auxiliary nurses in priority areas. Donor support should be focused on service delivery units that have the greatest chance of success. Thus, instead of a top-down grant, the team suggests a grant that concentrates on strengthening the reproductive health and family planning capability of individual Maternal-Infant Health Clinics (MIHC) that are being established around the country. It might be useful to select the clinics through a competitive process to ensure that they are committed to the grant objectives. If ASHONPLAFA decides to add birthing centers to its satellite clinics, these could also be included in the project.

The PVOs should continue to develop self-sustaining reproductive health care systems among the communities with which they work. As a community becomes more self-reliant, the PVOs should decrease their support in that area and move on to another area. ASHONPLAFA should help to build technical capability in MOH service delivery units and in the communities, as appropriate, and also move on to other areas once that capability is sustainable.

Coverage potential should be a key criterion in the selection process. The objective should be to start with those communities and centers with significant unmet demand and high potential for success. The areas where PRODIM and ASCH are working, for example, have a total population of 459,000, which represents 11 percent of the rural population. By careful selection of project sites, it may be possible to cover 30 to 50 percent of the rural population over the next five years.

# APPENDICES

# APPENDIX A

## Scope of Work

## I. PROJECTS TO BE EVALUATED

Two projects will be evaluated concurrently. They are the Health Sector II Project (522-0216) and the Private Sector Population III Project (522-0389).

The Health Sector II Project was authorized in May, 1988 and had an original Project Assistance Completion Date (PACD) of October 1, 1995. In the spring of 1995, the PACD was extended to September 30, 1996, through a non-funded Project Agreement Amendment. A mid-term evaluation of the Project was conducted between April 27 and June 4, 1995. Subsequently, the Project was amended on July 31, 1996, effectively extending the Project for three more years and increasing USAID's authorized contribution from $57.3 million to $68.4 million (PROAG Amendment 22). The current PACD of the Project is September 30, 1999.

The Private Sector Population III Project was authorized on September 27, 1995 with a PACD of December 31, 2000. The authorized USAID contribution is $11.2 million. An evaluation of the predecessor project (Private Sector Population II Project), which was authorized in July, 1989, was conducted between October 9 and November 18, 1994.

## II. PURPOSE OF THE EVALUATION

This evaluation will assist USAID/Honduras, the Government of Honduras and the Asociación Hondureña de Planificación de Familia (ASHONPLAFA), the International Planned Parenthood Federation affiliate in Honduras, in making adjustments, if needed, to the on-going projects and provide direction for the development of follow-on activities. The evaluation will:

-- Assess in what ways and to what extent the projects are contributing to USAID/Honduras' strategic objective of "Improved Family Health."

-- Identify implementation constraints of the projects and propose recommendations for the remainder of the life of the projects in terms of priorities, strategies and definition of outputs and targets.

-- In light of USAID/Honduras' new Strategic Plan for FY 1998-2003, identify future activities which will effectively contribute to the Mission's new health objective of "Sustainable Improvements in Family Health."

The Mission will need the results of the evaluation by July 1, 1998.

The evaluation of the Health Sector II Project will not include an evaluation of the HIV/AIDS component. This component was evaluated between August 12 and September 11, 1996. The results of the evaluation provided guidance to the Mission in developing a private sector HIV/AIDS prevention project, which would be initiated after the world-wide AIDSCAP project ended in 1997. In August, 1997, the local AIDSCAP project terminated. On February 17, 1998, a Cooperative Agreement was awarded to the Fundación Fomento en Salud (FFS) to become a National Center for AIDS Awareness and Prevention and to promote STD/HIV prevention and STD treatment throughout the country. FFS will sign sub-agreements with qualified local Honduran NGOs in April, 1998 to carry out these activities. Thus, since the project with FFS is just beginning, it would be premature to evaluate it now.

## III. BACKGROUND

### A. Health Sector II Project

As mentioned above, the Project was amended on July 31, 1996, extending the Project to September 30, 1999. The project extension was designed to further USAID's and the Ministry of Health's long-term effort to establish a "Sustainable and Effective Public Primary Health Care System" nationally by focusing technical assistance and resources on the most salient supply-side problems -- both adminstrative and technical -- which hinder further progress in reducing maternal and infant mortality in rural areas. The development hypothesis underlying the extension was that "a sustainable and effective public primary health care system" would increase the use of selected child survival interventions, of reproductive health and family planning services, and of STD/AIDS prevention practices. Use of these essential interventions in turn would result in "improved family health."

The extension calls for a four-pronged approach:

1. Improved delivery of child survival, reproductive health and family planning services in nine focus Health Areas, which have approximately 226 clinics and hospitals and serve approximately 25 percent of the nation's population.

2. National systems and policies strengthened in 15 demonstration Health Areas to improve decentralized financial management and local cost recovery, and to improve supervision, management and health information systems, health education and the vehicle and equipment supply and maintenance systems.

3. Improved delivery of STD/AIDS prevention and STD treatment programs among high-risk target groups in San Pedro Sula, Tegucigalpa, La Ceiba and Comayagua.

4. Maintenance of highly effective national programs by providing limited support to such activities as the expanded program of immunization, oral rehydration therapy and environmental health.

During the Annual Results Review (ARR) in November, 1997 when progress of the Mission's health and population projects were reviewed, it was reported that, of the 52 indicators for the Health Sector II Project, one was exceeded, 11 were met, and 20 fell short. The rest were either ongoing or not yet implemented. Some of the problems with the Project were due to the fact that project implementation in 1997 was delayed by 5 months due to the Annual Work Plan approval process. In addition, 4 months were spent transferring the signature authority from the outgoing to the incoming director of the Project Coordination Unit (PCU), which disburses Project funds. As a result, the Project had to rely on a relatively slow mechanism for disbursing the local cost budget. Training in the 9 focus Health Areas was also delayed until September, 1997.

Administrative, financial and technical constraints to improving the public primary health care system have also been well documented in other reports, which will be made available to the evaluation team. Given the limited resources and short time available under the Project extension to address these constraints, it is clear that a substantial new program in health reform, currently planned to coincide with a new World Bank sector loan and begin in FY 1999, will be required.

**B. Private Sector Population III Project**

The Private Sector Population III Project will contribute to the achievement of the Mission's strategic objective of "Improved Family Health" by helping to reduce Honduras' total fertility rate (TFR) from 4.7 in 1995 to 4.2 by 2001. This will be done by increasing the use of reproductive health services, including family planning services, among Honduran women of fertile age. At the same time, efforts funded under the Project will increase ASHONPLAFA's financial self-sufficiency from 31 percent in 1995 to 63 percent in the year 2000.

Project-funded activities will lead to six intermediate results:

1. Improved delivery of medical and clinical services.

2. Accessible, high quality, self-financing social marketing program.

3. Focused, high quality community-based distribution program.

4. Effective information, education, and communication strategy.

5. Effective support systems at the headquarters and in the regional offices.

6. Increased PVO participation in reproductive health.

ASHONPLAFA has received a substantial amount of technical assistance from USAID-supported Cooperating Agencies (CA) in order to achieve these results. Because of their number and importance, CA trip reports will be made available to the evaluation team after they arrive in Honduras.

The technical assistance appears to be paying off. For example, the self-sufficiency goal of 48 percent that ASHONPLAFA set for 1997 was achieved. This was due to down-sizing, the implementation of cost controls, adjustments in prices of services and products to clients, and the diversification of services. In addition, the institutionalization of Quality Assurance (QA) in ASHONPLAFA has been a great success. Examples of how QA has improved ASHONPLAFA's services include reductions in patient waiting time for services, improved flow of patients through the clinics, the availability of services in the afternoons and more comfortable waiting areas.

Perhaps the greatest accomplishment seen thus far under the Project has been the change in the institutional culture of ASHONPLAFA. ASHONPLAFA has made significant progress in changing its organizational culture from a social, non-profit orientation to a business-oriented one. As a result, ASHONPLAFA as an institution, now thinks in terms of self-sufficiency, rather than dependency on external donors, and is managing for results.

The most unsettling problem that ASHONPLAFA has experienced since 1996 is its inability to maintain Couple-Years-of-Protection (CYP) achievement at 1995 levels. For example, only 76 percent of this goal was met in 1997. An examination of the achievements of ASHONPLAFA's three service delivery programs reveals that the Medical/Clinical program achieved 73 percent of its goal, while the Social Marketing program achieved only 53 percent of its goal. In contrast, the Community Services program achieved 96 percent of its goal.

A decision was made late in 1996 that ASHONPLAFA's principal goal is to reach self-sufficiency in the shortest time possible without a decrease in the quality of services that the organization provides. This meant that ASHONPLAFA's plans to expand services in an attempt to increase CYPs were put on the back burner. Thus, it appears that the only way ASHONPLAFA will be able to increase CYP achievement is by providing family planning services to poor Hondurans, which will be subsidized by the profits earned from ASHONPLAFA's diversified, non-family planning services. It should be noted that ASHONPLAFA is attracting a clientele which is capable of paying full price for non-family planning services. However, some of these services are not yet profitable.

During the Annual Results Review (ARR) in November, 1997, it was reported that, of the 46 indicators for the Private Sector Population III Project, two were exceeded, 36 were met, and eight fell short. Of those which fell short, three were related to CYP production and two to national campaigns which are designed to establish ASHONPLAFA as the major provider of family planning and reproductive health services for middle class women and men.

Given that self-sufficiency is now ASHONPLAFA's principal goal, other strategies to increase contraceptive prevalence and reduce fertility in the country will need to be explored, and/or be postponed until after financial self-sufficiency has been achieved.

## C. Health Indicators

Family health in Honduras has improved significantly according to the 1996 national Epidemiology and Family Health Survey (EFHS). Infant mortality declined from 50 deaths per 1,000 live births in 1989 to 42 in 1993 (indirect estimate). This may be due in part to an increasing proportion of women who seek prenatal care and give birth in medical facilities, and to longer birth intervals. Although the infant mortality rate estimated for 1993 is half of that estimated for 1976, Honduras' current rate remains high in comparison with those of some other countries in the region, such as Costa Rica, which has a rate of 15 per 1,000 live births.

Fertility declined from 5.2 lifetime births per woman during 1989-91 to 4.9 during 1993-95, compared to the regional average of 4.3. Most of the decline in fertility is attributable to an increase in contraceptive use, from 40.6 percent in 1987 to 50.0 percent in 1996.

In 1996, 69 percent of households obtained their drinking water from faucets on the premises, compared to 56 percent in 1991/92. The proportion of households with a flush toilet or a latrine increased from 60 percent to 74 percent in the same time period.

Exclusive breastfeeding (2 to 3.99 months) increased from 23.2 percent in 1991/92 to 29.5 percent in 1996.

Despite these gains, important differentials exist for almost all indicators. For example, the total fertility rate (TFR) estimated for Tegucigalpa and San Pedro Sula, the two most important urban centers of the country, is 3.1 children per woman. In rural areas, the rate is 6.3 children per woman. Lower levels of education are strongly correlated with higher fertility. The TFR for women with no formal education is 7.1 children compared to 2.9 children among women with at least 7 years of education.

Contraceptive use varies by residence, ranging from a high of 62 percent in urban areas to a low of 40 percent in rural areas. Since the beginning of the current decade, the rate of increase in contraceptive use has declined and, in urban areas, contraceptive use has not changed significantly since 1987.

Based on direct estimates of infant mortality, neonatal mortality now accounts for more than half of all infant mortality. Nevertheless, postneonatal and child mortality remain relatively high among children of rural women and less educated women, in part due to the higher fertility among these women and to childhood malnutrition as an underlying risk factor.

According to the 1996 survey data, birth trauma, prematurity and congenital malformation taken together were the principal cause of under-five mortality (31 percent), followed by acute respiratory infections (24 percent) and diarrhea (21 percent).

The percentage of women aged 15-49 who have ever had a pap smear ranges from a high of 74 percent among women living in Tegucigalpa or San Pedro Sula to a low of 35 percent among women living in rural areas. The only indicator on which rural women fare better than urban women is the number of doses of tetanus toxoid received during their lifetime.

Differentials also exist with regard to health service utilization. For example, while approximately 89 percent of urban women receive prenatal care, only 80 percent of rural women receive this care. Similarly, only 32 percent of rural women give birth in a medical facility compared to 77 percent of women living in small towns and 91 percent of women living in Tegucigalpa or San Pedro Sula.

## D. Conclusion

Honduras has made impressive progress in improving family health. A comparative study conducted by the Centers for Disease Control and Prevention (CDC) concluded that Honduras was doing substantially better than its neighbors on achieving high coverage of primary health care services despite its low socioeconomic status. However, a great deal remains to be done with respect to reproductive health, family planning, infant and child mortality.

For example, the decrease in fertility mentioned above is by any standard rather modest, and it occurred principally in urban areas. The potential for further declines in fertitlity among urban, better educated women is very limited, as can been seen by comparing current fertility to desired fertility. There is, however, a large gap between actual family size and ideal family size in rural areas (6.5 vs. 3.3), suggesting that rural women may be receptive to using contraception, either for spacing their births or for stopping childbearing once a certain family size is reached. The main thing that is lacking in rural Honduras is adequate access to high quality family planning services, including surgical contraception. Enhanced family planning services need to be provided by the Ministry of Health throughout its health care system, especially in rural areas, where ASHONPLAFA is unable to provide full and adequate coverage, even though it is in rural areas where maternal mortality and total fertility rates are highest.

Because neonatal mortality now accounts for more than half of all infant mortality, efforts will have to concentrate more on reducing the perinatal causes of these deaths, including the promotion of prenatal care, maternal dietary supplementation, safe delivery, and better care of the newborn. Additional efforts are also needed to improve the treatment of pneumonia and the use of oral rehydration therapy.

## IV. STRATEGIC PLAN FOR FAMILY HEALTH

Poor health and rapid population growth are critical roadblocks to the ability of Honduras to achieve sustainable development. Beginning with FY 1998, USAID/Honduras has incorporated the concept of "sustainable" into its current objective of "improved family health" to place much greater emphasis on strengthening financial, institutional and managerial systems in order to maintain or continue improving reproductive health, child survival and food security despite declining resources. Thus, the Mission has chosen the following as its SO3 statement:

**"Sustainable Improvements in Family Health"**

Specific examples of sustainability we hope to achieve by 2003 are: that ASHONPLAFA will be 85 percent self-financing; the Ministry of Health will be paying an increasing proportion of its recurrent costs including its contraceptive needs; a non-governmental Honduran Center for AIDS Awareness and Prevention will be fully established; and direct food aid distribution will decline in the rural west, as caloric inadequacy and indigence are gradually reduced. At the same time, maternal and infant mortality, fertility, and childhood nutrition will continue to decline while HIV seroprevalence stabilizes. Use of the key services that contribute to these achievements will be maintained or increased.

The SO3 results framework and performance indicators will be presented to the evaluation team after their arrival in country.

## V. STATEMENT OF WORK

The evaluation team will focus on answering the following questions. For all of the tasks specified, the evaluators will need to present:

-- their findings (i.e., the "evidence");

-- their conclusions (i.e., their interpretation of the evidence and their best judgment based on this interpretation);

-- their recommendations based on their judgments.

The evaluators must distinguish clearly between their findings, conclusions (that is, their interpretations and judgments), recommendations, and lessons learned.

### A. Health Sector II Project

### A.1 Family Planning

-- Evaluate what we have accomplished to date in achieving PROAG Amendment 22 family planning results indicators, especially the efforts to improve the

postpartum/postabortion family planning activities in the Hospital Escuela and other Ministry of Health hospitals; the auxiliary nurses reproductive health pilot project (including synthesizing findings of reports from the Population Council); and the family planning program of the Social Security Institute (IHSS).

-- To what extent is the Ministry of Health committed to family planning? How can family planning activities be expanded and strengthened in the Ministry of Health? What would be an acceptable MOH family planning strategy? What project assistance should be provided in this area?

-- Besides the unavailability of services, "institutional barriers," such as age and parity requirements, exist in the Ministry of Health which prevent more women from receiving a tubal ligation. What needs to be done to eliminate these "barriers" in order that surgical contraception be available upon demand? Would the Ministry of Health have the capacity to meet this demand if the "barriers" were eliminated? If not, how can USAID/Honduras help the Ministry of Health in increasing its capacity to provide surgical contraceptive services?

-- With Project assistance, the Hospital Escuela in Tegucigalpa has dramatically increased the number of tubal ligations it performs and the number of IUDs it inserts. What actions (training, equipment, renovation, logistics) would be needed to replicate this model in other Ministry hospitals and Maternal/Child Health clinics in the country? In terms of CYP production and the potential for reducing rural fertility (as measured by survey data), which hospitals and MCH clinics should receive priority attention?

-- How can the Ministry of Health supply system be strengthened in order to insure that clinics and hospitals always have an adequate supply of contraceptives and IUD insertion kits on hand? Similarly, how can the reporting of balances on hand of family planning commodities be improved in order that the procurement of additional supplies does not result in an under- or oversupply situation?

-- How could Ministry of Health supervision of family planning services be improved? What project assistance should be provided in this area?

-- How can the reporting of contraceptives dispensed and tubal ligations performed be improved, in order that reliable data are available in a timely fashion to calculate CYP achievement?

## A.2 Maternal and Neonatal Health Care

-- The 1996 survey data indicate that rural, less educated women prefer to go to a CESAMO rather than to a CESAR for prenatal care. For many women, a CESAR would be an adequate place to receive prenatal care. Why aren't women utilizing the prenatal services provided by CESARs? What efforts should be made to strengthen the image of

CESARs or should attention be given to increasing the number of CESAMOs in order to extend prenatal coverage? (See MotherCare sponsored perinatal practice study).

-- With regard to safe delivery and management of obstetric emergencies, evaluate what has been accomplished to date in achieving PROAG Amendment 22 results indicators. Advise on what the Mission and the MOH should do over the next 5 years to reduce maternal mortality due to obstetric emergencies in rural areas.

-- What would be an appropriate role for the Health Sector II Project in reducing perinatal mortality? What Project assistance should be provided in this area?

-- Why do pregnant women with life-threatening problems not get to health centers and hospitals? What can be done to establish more effective referral systems in rural areas for obstetric emergencies? What innovative approaches might be employed to address obstetric emergencies?

-- What can be done to increase the proportion of rural, less educated women who deliver in hospitals or MCH clinics? Does the Ministry of Health hospital network have the capacity to absorb an increase in institutional births? If not, what project assistance should be provided to the Ministry to increase its capacity?

-- What can be done to increase the proportion of all women who give birth who receive a timely postpartum checkup? How can postpartum care of the mother be effectively integrated with the care of the newborn?

**A.3 Child Survival**

-- The use of oral rehydration salts has not increased over the last 10 years. Why? What Project assistance, if any, should be provided in this area?

-- Children with severe cases of ARI and children dehydrated from their recent episode of diarrhea do not get to health centers or hospitals for treatment. What can be done to establish more effective referral systems in rural areas for these illnesses? Taking into account the recent cost-effectiveness study of community management of pneumonia, what should the Project do to advance community management of ARIs?

-- How should the project support the area-level hospitals in the treatment of pneumonias as the first line of referral in the primary health care system?

-- Immunization coverage of children under one with the four traditional vaccines has remained at over 90 percent and of pregnant women with 2 doses of tetanus toxoid at over 95 percent. Thus, what would be an appropriate strategy for reducing and finally terminating Project support of the cold chain, including travel costs and per diems of vaccinators?

## A.4 Rural Water and Sanitation

-- How well has SANAA done in using its Project experience to develop partnerships with other donors to continue extending coverage?

-- What effect has the creation of the "Tecnicos de Agua y Saneamiento" (TAS) and the "Tecnicos de Operacion y Mantenimiento" (TOM) had on the efficiency and effectiveness of SANAA's rural programs? Has SANAA taken on this program as their own? What further actions need to be taken to strengthen this program?

-- How effective has SANAA been in training villagers in the operation and maintenance of the water systems?

-- In light of the fact that USAID funds for construction of additional water systems and latrines are no longer available, how should USAID/Honduras continue to support the water and sanitation sector given that it is so crucial to improving health?

## A.5 Sustainable Support Systems

-- Evaluate what we have accomplished to date in achieving PROAG Amendment 22 results indicators in terms of supervision, health information systems and management information systems. Should the project continue with the activities? Why or why not? If, yes, how should the project proceed?

-- Review the implementation of the Administrative Reform effort supported by the Project (SIGAF). Has or will this effort produce meaningful results? Elaborate on what those results have been or will be, discussing the benchmarks and indicators proposed in the project design.

-- Evaluate the extent to which the PROAG Amendment 22 convenant on MOH assessment of costs and savings of new technologies and administrative systems, and MOH resource allocation to the rural, primary health care has been accomplished.

-- How do the new health authorities view such topics as health reform, cost recovery and sustainability? What plans do the new health authorities have to increase the efficiency and sustainability of the Ministry of Health? How do our new partners in the MOH perceive the Mission's results orientation? From their perspective, will management for results make a difference? If so, how?

## B. Private Sector Population III Project

### B.1 Sustainability

-- To what extent has the administrative reorganization of ASHONPLAFA increased delegation of authority from the central office and given the regional offices increased latitude to plan and manage their programs? Are the regional directors sufficiently trained to manage their programs? If not, what additional training do they need?

-- If decentralization has occurred, is the maintenance of a large central staff justified? If not, what changes need to be made to downsize the central staff?

-- To a certain extent, ASHONPLAFA has been successful in reducing its operating costs. What additional steps can ASHONPLAFA take to further reduce its operating costs, and to increase productivity and efficiency?

-- ASHONPLAFA has diversified its services in order to improve its self-sufficiency profile. Not all of its diversified services are profitable. What needs to be done to make them profitable? Should some current services be dropped because they will never be profitable? What additional non-family services would be feasible for ASHONPLAFA to offer in order to improve its profitability?

-- The diversified services are designed to attract middle class men and women to ASHONPLAFA's facilities. Are the facilities suitable enough for this type of clientele? Are the persons who staff these services appropriate to deal with this type of clientele? What additional steps does ASHONPLAFA need to take in order to attract the middle class to its facilities?

-- According to the 1996 survey data, a sizeable number of men and women who have the ability to pay for health services utilize the services of the Ministry of Health. The survey data also show that the use of private sector health services is low, especially in the two major urban centers of the country, Tegucigalpa and San Pedro Sula. What can ASHONPLAFA do to fill this void in the private sector?

-- What is the operational definition of financial self sufficiency used by the PSPIII Project? How is it measured by ASHONPLAFA? How is it measured by family planning programs in other countries? Discuss any differenecs in definition or measurement methodology and make recommendations for the case of ASHONPLAFA.

### B.2 CYP Achievement

-- CYP achievement has declined over the past two years, particularly in the Medical/Clinical program and the Social Marketing program. What explains this decline

and what can be done to reverse this trend? How does the new method of paying physicians (riesgo compartido) affect CYP achievement of the Medical/Clinical program?

-- What can be done to assure that ASHONPLAFA continues to focus on family planning while diversifying it services to increase income?

-- In 1997, the Social Marketing program was responsible for less than 10 percent of ASHONPLAFA's total CYP achievement. Should this program be continued? Why or why not? What would be the impact of eliminating this program on ASHONPLAFA's total CYP achievement and self-financing goals?

-- ASHONPLAFA's Community Services program has been functioning relatively well over the past 5 years, producing about a third of ASHONPLAFA's total CYP achievement in 1997. However, what can USAID/Honduras do to help improve this program in increasing the prevalence of contraceptive use in rural areas without sacrificing self-sufficiency?

-- In an effort to expand private sector family planning services in rural Honduras, USAID awarded grants to Save the Children and PRODIM, two local PVOs, in 1997. USAID is planning to award two more grants in 1998. In terms of coverage and efficiency, does it make sense to award grants to two more PVOs, or would it be better to grant the money to ASHONPLAFA to expand its rural family planning services? How well are PRODIM and Save the Children working with ASHONPLAFA and the Ministry of Health?

**B.3 Support Systems**

-- To what extent have the systems been implemented? To what extent have the data generated by these systems been effectively used in planning and decision-making? How can these systems and their use be further strengthened?

**B.4 Other**

-- ASHONPLAFA has been approached by the USAID regional HIV/AIDS condom social marketing project (PASMO) to collaborate in the distribution of the regional project's "Vive" condom. Would it make sense for ASHONPLAFA to collaborate with PASMO? If not, is it feasible for ASHONPLAFA to market an HIV/AIDS condom of its own in Honduras? Could ASHONPLAFA achieve the national coverage that would be needed to reduce the transmission of HIV in high risk groups and in the general population? Would other donors be interested in supporting ASHONPLAFA in marketing an HIV/AIDS condom?

-- During the last two years, ASHONPLAFA has received a substantial amount of technical assistance from USAID-supported Cooperating Agencies (CA). Mission population funds, however, are becoming scarce. Thus, the Mission is not in a

position to provide the same level of technical assistance to ASHONPLAFA in future years. Make recommendations as to which programatic, administrative and managerial areas in ASHONPLAFA need to continue to receive technical assistance, listing these areas in order of priority.

-- How well is ASHONPLAFA working and coordinating with PRODIM, Save the Children, and the Ministry of Health?

-- The Private Sector Population III Project had called for three reproductive health committees (training, services and IEC). As things have evolved, there is just one reproductive health working group organized by the Population Council. How effective is this working group?

## C. CROSS-CUTTING ISSUES

-- Advise the Mission on what it should do over the next 5 years to increase rural contraceptive prevalence by at least 10 percentage points.

-- How effective has the local Population Council been in providing technical assistance to the Ministry of Health, ASHONPLAFA and other PVOs/NGOs?

## VI. METHODS AND PROCEDURES

The Chief of Party (COP) will visit the country 10 days prior to the evaluation to meet with USAID/Honduras technical officers and MOH and ASHONPLAFA counterparts. He/she will also collect background documents and prepare a draft of the field methodology, including a schedule of field visits to be approved by USAID/Honduras. The full team will have a two-day planning meeting in the U.S. to review their scopes of work, the field methodology, and to study background documents.

Prior to the arrival of the COP, the Ministry of Health and ASHONPLAFA will have named technical counterparts to each of the team members. The counterparts will participate actively in all meetings, visits, and activities of the members of the evaluation team. Per diem for their field trips will come from evaluation contractor.

## VII. COMPOSITION OF EVALUATION TEAM

The team will consist of a Chief of Party (COP), a Maternal and Neonatal Health Specialist, a Child Survival Specialist, a Water and Sanitation Specialist, a Family Planning Program Sustainability Specialist, a Family Planning Program Specialist, a Family Planning Management Systems Analyst, and a Logistics Specialist.

**A. Chief of Party (8 weeks)**

1. SOW

The COP will coordinate all phases of the evaluation, including the field methodology and logistics, and the preparation and submission of the draft and final reports. He/she will be responsible for the contraceptive Social Marketing questions in this evaluation and the cross-cutting issues.

2. REQUIREMENTS

-- A master's or doctorate degree in a health related field or an MD/MPH.

-- Prior experience in the evaluation of PHC and/or family planning programs.

-- 10 years of experience in the management of public health care and family planning programs in developing countries, eg., former COP of an institutional contractor in a Latin American country that provided technical assistance to an MOH program.

-- Fluent in Spanish (FS-3 level) and English.

**B. Maternal and Neonatal Health Specialist (5 weeks)**

1. SOW

The Maternal and Neonatal Health Specialist will be responsible for preparing all sections of the report pertaining to prenatal care, safe delivery, postpartum care, maternal and neonatal health in the Ministry of Health. He/she will perform other duties as determined to be necessary by the COP.

2. REQUIREMENTS

-- A master's or doctorate degree in a health related field or an MD/MPH.

-- Prior experience in the evaluation of maternal and neonatal health programs.

-- 7 years of experience in programs delivering reproductive health services in developing countries, preferrably in Latin America.

-- Fluent in Spanish (FS-3 level) and English.

**C. Child Survival Specialist (3 weeks)**

1. SOW

The Child Survival Specialist will be responsible for preparing all sections of the report pertaining to child survival in the Ministry of Health. He/she will perform other duties as determined necessary by the COP.

2. REQUIREMENTS

-- A master's or doctorate degree in a health related field or an MD/MPH.

-- Prior experience in the evaluation of PHC programs.

-- 7 years of experience in programs delivering child survival services in developing countries, preferrably in Latin America.

-- Fluent in Spanish (FS-3 level) and English.

**D. Water and Sanitation Specialist (2 weeks)**

1. SOW

The Water and Sanitation Specialist will be responsible for preparing all sections of the report pertaining to the rural water and sanitation program of the Ministry of Health and SANAA.

2. REQUIREMENTS

-- A master's degree in sanitary/environmental engineering or health.

-- Prior experience in the evaluation of water and sanitation/environmental health programs.

-- 5 years of experience in water supply and sanitation programs in developing countries, preferrably in Latin America.

-- Fluent in Spanish (FS-3 level) and English.

**E. Family Planning Program Sustainability Specialist (4 weeks)**

1. SOW

The Family Planning Program Sustainability Specialist will be responsible for preparing all sections of the report pertaining to sustainability in ASHONPLAFA. He/she will perform other duties as determined necessary by the COP.

2. REQUIREMENTS

-- A master's degree in a health related field or an MD/MPH.

-- Prior experience in the evaluation of family planning programs.

-- 5 years of experience in designing and implementing sustainable family planning programs in developing countries, preferrably in Latin America.

-- Fluent in Spanish (FS-3 level) and English.

**F. Family Planning Program Specialist (6 weeks)**

1. SOW

The Family Planning Specialist will be responsible for preparing all sections of the report pertaining to family planning in ASHONPLAFA and in the Ministry of Health. He/she will perform other duties as determined necessary by the COP.

2. REQUIREMENTS

-- A master's degree in a health related field or an MD/MPH.

-- Prior experience in the evaluation of family planning programs.

-- 5 years of experience in designing and evaluating sustainable family planning programs in developing countries, preferrably in Latin America.

-- Fluent in Spanish (FS-3 level) and English.

**G. Management Systems Analyst (6 weeks)**

1. SOW

The Management Systems Analyst will be responsible for preparing all sections of the report pertaining to the management systems in ASHONPLAFA and the sustainable

support systems in the MOH. He/she will perform other duties as determined necessary by the COP.

2. REQUIREMENTS

-- A master's degree in a health related field or an MD/MPH.

-- Prior experience in the evaluation of health and family planning program management systems.

-- 5 years of experience in designing and implementing health and family planning management systems in developing countries, preferrably in Latin America

.

-- Fluent in Spanish (FS-3 level) and English.

**H. Logistics Specialist (3 weeks)**

1. SOW

The Logistics Specialist will be responsible for preparing the section of the report pertaining to the MOH's supply/logistics system.

2. REQUIREMENTS

-- A master's degree in a health related field.

-- Prior experience in the evaluation of supply/logistics systems in Ministries of Health.

-- 5 years of experience in designing and implementing logistics systems in developing countries, preferrably in Latin America.

-- Fluent in Spanish (FS-3 level) and English.

## VIII. REPORTING REQUIREMENTS

The evaluation team will prepare a written report for each project, containing the following sections:

-- Table of Contents

-- Abbreviations used in the report

-- Executive Summary (which shall be a self-contained document that does not exceed three pages)

-- Body of the report (approximately 35 pages)

> the purpose and study questions of the evaluation

> the economic, political and social context of the project

> team composition, field of expertise and role each member played in the evaluation

> study methodology (one page maximum)

> findings of the evaluation

> conclusions

> recommendations

> lessons learned

Each of the line items listed above should be presented in separate sections of the report. Detailed descriptions and background documentation should go into annexes to the report.

The report will provide the information (evidence and analysis) on which the conclusions and recommendations are based.

Conclusions should be short and succinct, with the topic identified by a short subheading related to the question posed in the Statement of Work.

Recommendations should correspond to the conclusions. Whenever possible, the recommendations should specify who or what organization should be responsible for the recommended actions.

Lessons learned should describe the causal relationship factors that proved critical to project success or failure, including political, policy, economic, social and bureaucratic preconditions within the host country and USAID. These should also include a discussion of the techniques or approaches which proved most effective or had to be changed, and why.

-- Appendices will include at a minimum the following:

> the evaluation Scope of Work
> a description of the methodology used in the evaluation
> a bibliography of documents consulted
> a list of individuals contacted

Under the direction of the COP, the evaluation team will prepare and submit English and Spanish draft reports on the evaluation of each Project to USAID/Honduras. For the discussion which follows, week #1 corresponds to the first week the evaluation team is in country.

By Wednesday of week #6, the team will submit a first draft of the evaluation reports, with annexes and a diskette (WP5.2 format). Ten copies in English and ten in Spanish of each report will be submitted. USAID/Honduras, MOH and ASHONPLAFA officials will review the draft reports and provide preliminary comments to the COP by COB Tuesday of week #7. The COP will incorporate feedback from USAID, the MOH and ASHONPLAFA into a second draft reports and distribute them (ten copies in English and ten copies in Spanish of each report) with diskette to USAID prior to his/her departure at the end of week #7.

USAID, the MOH and ASHONPLAFA will have 10 working days to provide additional comments to the contractor on the second draft of the evaluation reports. The contractor will then have an additional 10 working days to incorporate USAID, MOH and ASHONPLAFA comments and present the final report and diskette to the Mission. Twenty copies in English and ten in Spanish of each report will be submitted to USAID/Honduras.

The evaluation team will brief USAID, the MOH and ASHONPLAFA separately regarding their findings, conclusions and recommendations prior to departure of the team. This will be done during week #6.

## IX. BUDGET

An illustrative budget is attached. A six-day work week is authorized for the in-country portion of this Scope of Work.

==========

**Amendment to VII: Reporting Requirements**

During negotiations between USAID/Honduras and POPTECH, the schedule was modified as follows:

| | |
|---|---|
| Debriefing with USAID, ASHONPLAFA, MOH | June 15 |
| Draft report submitted by the Team | June 16 |
| Comments on the report from USAID, ASHONPLAFA and MOH submitted to the Team | June 19 |
| Submission of final English draft and translation of key findings and recommendations to USAID, MOH, ASHONPLAFA and POPTECH on | June 26 |
| POPTECH edits report and submits clearance draft to USAID | July 17 |
| POPTECH receives formal written clearance on report from USAID | July 31 |
| POPTECH sends report for Spanish translation | July 31 |
| Twenty copies of English report distributed to USAID/Honduras | August 7 |
| Ten copies of Spanish translation distributed to USAID/Honduras | August 14 |

# APPENDIX B

## Documents Reviewed


Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Boletín Estadistico Anual 1994.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Boletín Estadistico Anual 1995.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Boletín Estadistico Anual 1996.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Informe Estadistico Anual 1997.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Informe Estadistico, Primer Trimestre 1997.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Informe Estadistico, Primer Trimestre 1998.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Plan de Mercadeo, 1997, Program de Mercadeo Social.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Plan de Acción Año 1995.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Plan de Acción Año 1996.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Plan de Acción Año 1997.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Plan de Acción Año 1998.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Resultados/Indicadores n.d.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Plan Estrategico 2001, Preparado por ASHONPLAFA con financiamiento de USAID/Honduras y Asistencia Técnica de IPPF/WHR, 1997.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Estudio sobre Calidad de Atención y Satisfacción de Usuarias del Programa Médico Clínico. División de Investigación, Evaluación y Planamiento n.d.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA). Estudio Calidad de Atención y Satisfacción del Cliente, Programa Médico Clínico. División de Investigación, Evaluación y Planamiento. Noviembre 1997.

Asociación Hondureña de Planificación de Familia (ASHONPLAFA Conclusiones y Recommendaciones sobre el Proyecto Clínico de Métodos Temporales en La Ciudad de (Yoro, Lima, Villanueva, Choloma). División de Investigación, Evaluación y Planamiento. Noviembre 1997.

Encuesta Nacional de Epidemiologia y Salud Familiar, 1996. Informe Resumido.

Encuesta Nacional de Epidemiologia y Salud Familiar, 1996. Esterilización Femenina.

Encuesta Nacional de Epidemiologia y Salud Familiar, 1996. Demanda para Esterilización Femenina.

Encuesta Nacional de Epidemiologia y Salud Familiar, 1996. Planificación Familiar.

Cobb, Laurel, Dave Denman, Victor Jaramillo and A. Rizo. Evaluation of the USAID/Honduras Private Sector Population II Project (522-0369). POPTECH Report No. 94-015-23, July 1995.

USAID/Honduras. Project Paper: Private Sector Population III Project (522-0389), September 27, 1995.

USAID/Honduras. Strategic Plan (FY 1998-2003), May 1997.

USAID/Honduras. Results Review and Resource Request (R4), May 1997.

USAID/Honduras. SO3 1997 Annual Results Review (ARR) and Issues. November 21, 1997.

# APPENDIX C

## Evaluation Contacts

**USAID**
Dr. Mary Ann Anderson, Director, Human Resources Development
Dra. Maria del Carmen Miranda, Population Advisor
Mr. Richard Monteith, TAACS Advisor
Dr. David Losk, Chief, Health/Population/Nutrition Division

**ASHONPLAFA, Central Office**
Lic. Carlos Morlacchi R., Executive Director
Lic. Juanita Josefa Martinez, Chief, Planning and Project Coordination Division
Lic. Germán Humberto Cerrato, Chief, Administration and Finance Division
Lic. Suyapa Pavón, Chief, Research, Evaluation and Statistics Division
Dr. Manuel Sandoval, Director, Medical Services
Lic. Nelly Elizabeth Fúnez, Chief, Regional Division
Lic. Ricardo Reyes, Chief, Sales Division
Lic. Roger Castro, Chief, Social Marketing Program
Profa. Daisy Cruz, Director Community Services Program
Lic. Lenín Flores Anduray, Director, Information, Communication and Marketing Division
Sr. Luis Enrique Guzman, Chief, Promotion, Publicity and Public Relations
Lic. Maria Roberta Bulness, Chief, Human Resources Division
Lic. Janeth de Cerritos, Internal Training
Lic. Elena de Perez, External Training

**ASHONPLAFA, Field Visits**

**Region I, Tegucigalpa**
Lic. Adma Lastenia de Cerrato, Chief
Sra. Reina Galindo, Community Services Supervisor
Sra. Ada Luz Berlioz, Reproductive Health Promoter, Comayagua Clinic
Dr. Edwin Padilla, Physician, Comayagua Clinic
Sra. Nitzia Soler, Saleslady, Barrio Cabanas, Comayagua
Sra. Candida Lopez, Saleslady, Liconas, Comayagua
Sra. Norma Avila, Saleslady, Ajuterique
Sra. Marlen Lagros, Counseling Assistant, Tegucigalpa Clinic
Sr. Gloria Flores, Counselor, Tegucigalpa Clinic
Lic. Orbelina Hernandez, Professional Nurse, Tegucigalpa Clinic
Dr. America Chirinos, Physician, Tegucigalpa Clinic
Lic. Rosaria Tilguat, Professional Nurse, Danlí Clinic
Sra. Concepción Savala, Reproductive Health Promoter, Danlí Clinic

**Region II, San Pedro Sula**
Profa. Maria de Jesús Alvaredo de Mejia, Chief
Sr. Juan Carlos Velasquez, Accountant
Sr. Joel Duran, Supply Officer
Cont. Ramiro Hernandez, Sales and Community Services Supervisor
Lic. Edith Castro, Professional Nurse, Puerto Cortés Clinic
Lic. Maria del Carmen Castro, Professional Nurse, El Progreso Clinic
Sra. Norma Mariaga, Librarian/Receptionist, San Pedro Sula Clinic
Sra. Yolanda Ruiz, Family Planning Counselor, San Pedro Sula Clinic

**Region III, Choluteca**
Lic. Carlos Melendez, Chief
Sr. Amadeo García, Community Services Promoter
Lic. Egla Elisa Espinoza, Professional Nurse, Choluteca Clinic

**Region IV, La Ceiba**
Cont. Pablo Dominguez, Chief
Profa. Norma Ayala de Montoya, Sales and Community Services Supervisor
Dr. Imilse Cubas, Physician, Tocoa Clinic
Lic. Sandra Canisales, Professional Nurse, Tocoa Clinic
Sra. Lucia de Valdez, Saleslady, Tocoa Clinic
Sra. Ortilla Rosales, Reproductive Health Coordinator, Tocoa Clinic

**Region V, Copán**
Lic. Jesús Humberto Chavez, Chief
Sra. Blaca Livia Vividor, Community Services Supervisor
Sr. Arnold Bueso, Sales Promoter
Dra. Irena Alvarado, Physician, La Entrada Clinic

**Region VI, Olancho**
Lic. Dilia Jimenez, Chief
Sr. Jairo Eloc Torres M., Rural Sales Promoter
Sra. Liliana Medina Ayala, Reproductive Health Promoter
Lic. Laticia Lizzett Lanza, Professional Nurse, Juticalpa Clinic

**Academy for Educational Development**
Lic. Orlando Hernandez, Advisor

**PRODIM**
Dr. Sadith Cácues, Executive Director

**SOMARC**
Lic. Juan Carlos Negrette, Regional Manager, Latin America/Caribbean

# APPENDIX D

# D-1 Contraceptive Prevalence Tables

| Table A 1 1 Current Use of Contraception (PF 15-B) | | | | | |
|---|---|---|---|---|---|
| | 1981 | 1984 | 1987 | 1991-92 | 1996 |
| All methods | 26 8% | 34 9% | 40 6% | 46 7% | 50 0% |
| Modern methods | 22 4% | 29 5% | 32 1% | 33 6% | 39 7% |

| Table A 1 2 Ever and Current Use of Contraception by Method (PF 13 and 14A) | | | | | | | |
|---|---|---|---|---|---|---|---|
| | F Ster | M Ster | Orals | IUD | Injection | Condom | Other |
| Ever use | 18 1% | 0 1% | 42 1% | 18 7% | 4 6% | 18 4% | |
| Current use | 18 1% | 0 1% | 8 5% | 9 9% | 1 1% | 32 0% | 10 1% |

| Table A-1 3 Current Use of Contraception by Age Group (PF 16) | | | | | | |
|---|---|---|---|---|---|---|
| | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 |
| All methods | 27 6% | 39 4% | 54 2% | 57 8% | 58 0% | 55 5% |
| Modern methods | 15 8% | 29 5% | 41 5% | 41 4% | 48 2% | 44 8% |

| Table A-1 4 Current Use of Contraception by No Living Children (PF 17A) | | | | | | |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4-5 | 6+ |
| All methods | 11 6% | 43 0% | 53 8% | 64 2% | 60 2% | 43 2% |
| Modern methods | 8 2% | 29 8% | 40 1% | 54 2% | 52 9% | 31 8% |

| Table A-1 5 Current Use of Contraception by Religion (Table PF 21B) | | | |
|---|---|---|---|
| | Catholic | Protestant | None |
| All methods | 49 1% | 52 9% | 48 6% |
| Modern methods | 38 5% | 42 2% | 39 5% |

| Table A-1 6 Current Use of Contraception by Religiosity (Table PF 21C) | | | | |
|---|---|---|---|---|
| | Very | Religious | Little | Not |
| All methods | 50 5% | 51 9% | 49 2% | 49 7% |
| Modern methods | 37 8% | 40 3% | 38 9% | 41 2% |

| Table A-1 7 Current Use of Contraception by Years of Education (Table PF 19A) | | | | |
|---|---|---|---|---|
| | 0 | 1-3 | 4-6 | 7+ |
| All methods | 34 8% | 42 7% | 52 5% | 64 3% |
| Modern methods | 25 4% | 32 4% | 43 4% | 51 2% |

| Table A-1 8 Current Use of Contraception by Socioeconomic Level (Table PF 20) | | | |
|---|---|---|---|
| | Low | Middle | High |
| All methods | 35 2% | 60 6% | 67 8% |
| Modern methods | 25 2% | 50 8% | 55 8% |

| Table A 1 9 Current Use of Contraception by Area of Residence (Table PF 15A) | | | |
|---|---|---|---|
| | TGU/SPS | Other Urbar | Rural |
| All methods | 66 9% | 57 2% | 40 4% |
| Modern methods | 57 7% | 46 5% | 29 9% |

| Table A-1 10 Current Use of Contraception by Source of Method (Table PF 31A) | | | | | |
|---|---|---|---|---|---|
| | All Public | Hosp MOH | CESAMO | CESAR | Hosp IHSS |
| Modern methods | 34 8% | 14 6% | 10 3% | 2 1% | 7 8% |

| Table A-1 11 Current Use of Contraception by Source of Method (Table PF 31A) | | | | | | | |
|---|---|---|---|---|---|---|---|
| | All Private | Pharm | Med/Clinic | AHFP Clin | AHFP Post | Other | Unknown |
| Modern methods | 65 3% | 13 0% | 11 8% | 26 8% | 10 2% | 2 6% | 0 9% |

D-2 ASHONPLAFA Benchmark Achievement 1997

| 1 Improved Medical/Clinical Service Delivery | Status |
|---|---|
| QA system established in any new service before such a service is initiated | Met |
| Exit interviews indicate that 95% of family planning users are satisfied with services received | Met |
| Rural brigades completed in rural areas of Copan | Met |
| Men s services offered in at least two regions other than Tegucigalpa and San Pedro Sula (Choluteca and Danli) | Met |
| Satellite clinics opened in small cities (Progreso and La Entrada) | Met |
| Total CYPs provided by MCP at the same level provided in 1995 | Fell short |
| New users of non-family planning services increased by 10% | Exceeded |
| Male VSC increased by 200% | Fell short |
| Pricing policy maintained throughout 1997 to keep up with inflation | Met |
| All clinics will generate at least 85% of their projected income for the year | Met |
| By mid-1997, reduce hours, stop payments to, or close those clinics not operating with at least 25% self-sufficiency | Met |
| Family clinics opened in at least two regions (5 regions) | Met |
| Two clinics initiated in existing facilities using contracted personnel with incentive plans (5 clinics) | Met |
| **2 Accessible, High Quality, Self-Financing Social marketing Program** | |
| Program is 110% self-sufficient | Fell short |
| Pricing policy maintained throughout 1997 to keep up with inflation | Met |
| SMP generating at least 85% of its projected income for the year | Met |
| SMP products accessible to low and middle-income clients in 95% of pharmacies | Met |
| Assessment of potential distributors other than MANDOFER | Met |
| Increased percentage of women and men knowledgeable about the contraceptive purchased | Met |
| Increased customer satisfaction with product and purchase of product | Met |
| Volume of sales likely to continue to be flat for orals | Met |
| Sales of Piel increased by 300% over 1996 level (not yet launched) | Fell short |
| **3 Focused, high-quality Community Service Program** | |
| Pricing policy maintains costs of one cycle of oral contraceptives and condoms at not more than 1% of minimum wage per region | Met |
| Recruitment and training of 20 *consejeras* and subsequent opening of CSP posts in rural and underserved areas of selected departments | Met |
| Recruitment and training of 10 *consejeras* and subsequent opening of CSP posts in periurban areas where pharmacies are not available | Met |
| Completion of baseline quality of care and client satisfaction studies | Met |

| | |
|---|---|
| EOP targets set | |
| Recommendations from the needs assessment of the CSP implemented in all six regions | Fell short |
| Restructured *consejera* training program in place | Fell short |
| Total CYP maintained at 1995 levels | Met |
| Total CYPs increased by 5% in periurban and urban areas, and by 8% in Regions 5 and 6 | Met in periurban and urban areas and fell short in regions 5 and 6 |
| CSP generates at least 85% of its projected annual income | Met |
| Real prices of CSP contraceptives maintained | |
| Posts in urban, periurban and rural areas with low CYP productivity will be closes | Met |
| **4 Effective Information, Education and Communication (IEC)** | |
| One national reproductive health campaign (with male component) completed | Fell short |
| One national image campaign completed | Fell short |
| **5 Effective Support Systems at Headquarters and Regions** | |
| HRM plan completely implemented by end of 1997 | Met |
| By end of Year 2, incentive plans for clinics and for social marketing, administration and community services will be initiated | Met |
| ASHONPLAFA assumes responsibility for 52% of the salary and benefits line items | Met |
| MIS will continue to present timely, accurate, reliable and relevant data to ASHONPLAFA relevant users | Met |
| MIS incorporates Quality Assurance standards, procedures and techniques for the MCP and CSP | Met |
| Finance Department continues to send out individual program and clinic monthly budget variance reports and comparative reports | Met |
| ASHONPLAFA 48% self-sufficient by end of 1997 | Met |
| At least 80% of all warehouse and distribution points at the regional and clinical level will have 80% of commodities at minimum stocking levels through the year | Met |
| Statistics Department has incorporated programmatic statistics into database | Met |
| Statistics Department producing bulletins on a quarterly semi-annual and annual basis | Met |
| Research Department completes 4 to 6 special purpose studies, and contracts out 2 to 4 special purpose studies and one OR study | Met |
| Evaluation unit completes quality and client satisfaction CSP baseline study | Met |

## D-3 ASHONPLAFA Self-Financing Analysis 1995-1997

| PROGRAMS | 1995 INCOME FOR THE PERIOD | 1995 EXPENSES & DIRECT COSTS | 1995 PERCENT SELF FINANCING | 1996 INCOME FOR THE PERIOD | 1996 EXPENSES & DIRECT COSTS | 1996 PERCENT SELF FINANCING | 1997 INCOME FOR THE PERIOD | 1997 EXPENSES & DIRECT COSTS | 1997 PERCENT SELF FINANCING |
|---|---|---|---|---|---|---|---|---|---|
| **MEDICAL/CLINICAL SERVICES** | | | | | | | | | |
| TEGUCIGALPA | 1 062 690 | 2 275 537 | 46 70% | 1 657 356 | 2 788 290 | 59 44% | 3 177 118 | 3 673 492 | 86 49% |
| SAN PEDRO SULA | 840 486 | 1 365 180 | 61 57% | 1 419 954 | 1 804 638 | 78 68% | 2 842 036 | 3 747 926 | 75 83% |
| CHOLUTECA | 381 733 | 583 921 | 65 37% | 425 864 | 822 135 | 51 80% | 737 444 | 934 429 | 78 92% |
| LA CEIBA | 479 264 | 772 186 | 62 07% | 700 760 | 1 049 359 | 66 78% | 1 092 588 | 1 372 805 | 79 59% |
| SANTA ROSA DE COPAN | 290 407 | 620 881 | 46 77% | 451 646 | 859 454 | 52 55% | 874 617 | 1 242 006 | 70 42% |
| JUTICALPA | 203 954 | 387 633 | 52 62% | 283 149 | 589 732 | 48 01% | 326 697 | 378 399 | 86 34% |
| **TOTAL** | **3 258 534** | **6 005 338** | 54 26% | **4,938 729** | **7,913 609** | 62 41% | **9 050 500** | **11 349 057** | 79 75% |
| **COMMUNITY SERVICES** | | | | | | | | | |
| TEGUCIGALPA | 871 311 | 1 397 278 | 62 36% | 1 098 976 | 1 179 430 | 93 18% | 1 518 565 | 1 194 971 | 127 08% |
| SAN PEDRO SULA | 686 691 | 1 021 570 | 67 22% | 1 033 031 | 1 122 572 | 92 02% | 1 317 831 | 1 203 976 | 109 46% |
| CHOLUTECA | 282 021 | 387 834 | 72 72% | 375 021 | 398 753 | 94 05% | 470 603 | 383 633 | 122 67% |
| LA CEIBA | 548 862 | 718 742 | 76 36% | 788 980 | 827 323 | 95 37% | 927 535 | 754 355 | 122 96% |
| SANTA ROSA DE COPAN | 284 773 | 478 723 | 59 49% | 418 499 | 579 664 | 72 20% | 530 209 | 614 917 | 86 22% |
| JUTICALPA | 167 478 | 294 050 | 56 96% | 217,143 | 272 496 | 79 69% | 275 092 | 281 565 | 97 70% |
| **TOTAL** | **2 841 136** | **4 298 197** | 66 10% | **3,931,650** | **4,380 239** | 89 76% | **5,039,835** | **4 433,417** | 113 68% |
| **SOCIAL MARKETING** | | | | | | | | | |
| CENTRAL ADMINISTRATION | 1 951 972 | 1 786 250 | 109 28% | 2 012 455 | 2 082 952 | 96 62% | 1 628 984 | 2 335 194 | 69 76% |
| **TOTAL** | **1,951 972** | **1,786 250** | **109 28%** | **2 012,455** | **2,082 952** | **96 62%** | **1 628 984** | **2 335 194** | **69 76%** |
| **SUPPORT PROGRAMS** | | | | | | | | | |
| CENTRAL REGION | 2 053 | 5 666 843 | 0 04% | 0 | 6 617 214 | 0 00% | 32 829 | 6 936 410 | 0 47% |
| TEGUCIGALPA | 18 550 | 1 090 530 | 1 70% | 30 953 | 174 673 | 17 72% | 83 998 | 1 484 232 | 5 66% |
| SAN PEDRO SULA | 579 | 613 303 | 0 09% | 18 911 | 150 091 | 12 60% | 25 208 | 1 151 110 | 2 19% |
| CHOLUTECA | 83 | 192 384 | 0 04% | 5 785 | 40 888 | 14 15% | 4 150 | 281 593 | 1 47% |
| LA CEIBA | 2 491 | 412 295 | 0 60% | 16 125 | 47 926 | 33 65% | 750 | 478 210 | 0 16% |
| SANTA ROSA DE COPAN | 3 903 | 321 777 | 1 21% | 11 038 | 54 177 | 20 37% | 8 565 | 387 126 | 2 21% |
| JUTICALPA | 1 737 | 362 621 | 0 48% | 2 332 | 34 665 | 6 73% | 0 | 113 031 | 0 00% |
| **TOTAL** | **29 396** | **8 659,753** | 0 34% | **85 144** | **7 119,634** | 1 20% | **155 500** | **10 831 712** | 1 44% |

| PROGRAMS | 1995 INCOME FOR THE PERIOD | 1995 EXPENSES & DIRECT COSTS | 1995 PERCENT SELF FINANCING | 1996 INCOME FOR THE PERIOD | 1996 EXPENSES & DIRECT COSTS | 1996 PERCENT SELF FINANCING | 1997 INCOME FOR THE PERIOD | 1997 EXPENSES & DIRECT COSTS | 1997 PERCENT SELF FINANCING |
|---|---|---|---|---|---|---|---|---|---|
| **ADMINISTRATION** | | | | | | | | | |
| CENTRAL REGION | 906 454 | 5 977 605 | 15 16% | 688 625 | 3 252 419 | 21 17% | 2 559 504 | 5 424 924 | 47 18% |
| TEGUCIGALPA | 0 | 0 | 0 00% | 86 520 | 820 623 | 10 54% | 16 617 | 132 153 | 12 57% |
| SAN PEDRO SULA | 17 043 | 958 089 | 1 78% | 14 661 | 705 136 | 2 08% | 22 591 | 1 200 372 | 1 88% |
| CHOLUTECA | 511 | 482 954 | 0 11% | 610 | 358 739 | 0 17% | 1 872 | 406 188 | 0 46% |
| LA CEIBA | 1 030 | 476 375 | 0 22% | 3 559 | 384 330 | 0 93% | 5 469 | 467 219 | 1 17% |
| SANTA ROSA DE COPAN | 6 120 | 401 330 | 1 52% | 10 977 | 310 636 | 3 53% | 7 250 | 421 401 | 1 72% |
| JUTICALPA | 2 626 | 379 470 | 0 69% | 4 139 | 300 536 | 1 38% | 15 319 | 276 376 | 5 54% |
| **TOTAL** | **933 784** | **8,675 823** | 10 76% | **809,091** | **6 132 419** | 13 19% | **2 628 622** | **8,328 633** | 31 56% |
| **TOTAL PROGRAMS AND CLINICS** | | | | | | | | | |
| CENTRAL REGION | 2 860 479 | 13 430 698 | 21 30% | 2 701 080 | 11 952 585 | 22 60% | 4 221 317 | 14 696 528 | 28 72% |
| TEGUCIGALPA | 1 952 551 | 4 763 345 | 40 99% | 2 873 805 | 4 963 015 | 57 90% | 4 796 298 | 6 484 848 | 73 96% |
| SAN PEDRO SULA | 1 544 799 | 3 958 142 | 39 03% | 2 486 557 | 3 782 437 | 65 74% | 4 207 666 | 7 303 384 | 57 61% |
| CHOLUTECA | 664 348 | 1 647 093 | 40 33% | 807 280 | 1 620 515 | 49 82% | 1 214 069 | 2 005 843 | 60 53% |
| LA CEIBA | 1 031 647 | 2 379 598 | 43 35% | 1 509 424 | 2 308 938 | 65 37% | 2 026 342 | 3 072 589 | 65 95% |
| SANTA ROSA DE COPAN | 585 203 | 1 822 711 | 32 11% | 892 160 | 1 803 932 | 49 46% | 1 420 641 | 2 665 450 | 53 30% |
| JUTICALPA | 375 795 | 1 423 774 | 26 39% | 506 763 | 1 197,429 | 42 32% | 617 108 | 1 049 371 | 58 81% |
| **TOTAL** | **9 014 822** | **29 425,361** | 30 64% | **11 777 069** | **27,628 852** | 42 63% | **18,503,441** | **37 278 013** | 49 64% |

# D-4 ASHONPLAFA Self-Financing Analysis, First Quarter 1997

| Medical Clinical Program<br>PROGRAMS CLINICS AND REGIONS | INCOME | EXPENSES AND DIRECT COSTS | PROFIT/ (LOSS) | PERCENT DISTRIBUTION BY REGION | PERCENT DISTRIBUTION BY GROUP | PERCENT DISTRIBUTION OF INCOME | PERCENT DISTRIBUTION OF COSTS | PERCENT DISTRIBUTION OF COSTS | PERCENT SELF FINANCING | PERCENT DISTRIBUTION SELF FINANCING |
|---|---|---|---|---|---|---|---|---|---|---|
| CENTRAL ADMINISTRATION | | | | | | | | | | |
| REGION I | | | | | | | | | | |
| Tegucigalpa | 849 218 | 835 946 | 13 272 | 84 37% | 28 80% | 13 60% | 32 24% | 10 12% | 101 59% | 10 28% |
| Danli | 86 262 | 39 078 | 47 184 | 8 57% | 2 93% | 1 38% | 1 51% | 0 47% | 220 74% | 1 04% |
| Comayagua | 71,032 | 41,211 | 29,821 | 7 06% | 2 41% | 1 14% | 1 59% | 0 50% | 172 36% | 0 86% |
| TOTAL REGION | 1 006 512 | 916 235 | 90 277 | 100 00% | 34 13% | 16 11% | 35 34% | 11 09% | 109 85% | 12 18% |
| REGION II | | | | | | | | | | |
| San Pedro Sula | 820 721 | 691 879 | 128 842 | 86 95% | 27 83% | 13 14% | 26 69% | 8 37 % | 118 62% | 9 93% |
| Puerto Cortes | 57 290 | 36 539 | 20 751 | 6 07% | 1 94% | 0 92% | 1 41% | 0 44% | 156 79 % | 0 69 % |
| El Progreso | 65,912 | 51,078 | 14,834 | 6 98% | 2 24% | 1 06% | 1 97% | 0 62% | 129 04% | 0 80% |
| TOTAL REGION | 943 923 | 779 496 | 164 427 | 100 00% | 32 01% | 15 11% | 30 07% | 9 43% | 121 09% | 11 42 % |
| REGION III | | | | | | | | | | |
| Choluteca | 220,329 | 198,655 | 21,674 | 100 00% | 7 47% | 3 53% | 7 66% | 2 40% | 110 91% | 2 67 % |
| REGION IV | | | | | | | | | | |
| La Ceiba | 279 545 | 268 145 | 11 400 | 82 08% | 9 48% | 4 48% | 10 34% | 3 24% | 104 25 % | 3 38 % |
| Tocoa | 61,047 | 45,695 | 15 352 | 17 92% | 2 07% | 0 98% | 1 76% | 0 55% | 133 60% | 0 74% |
| TOTAL REGION | 340 592 | 313 840 | 26 752 | 100 00% | 11 55% | 5 45% | 12 11% | 3 80% | 108 52% | 4 12% |
| REGION V | | | | | | | | | | |
| Santa Rosa de Copan | 226 296 | 231 441 | (5 145) | 70 33% | 7 67% | 3 62% | 8 93% | 2 80% | 97 78 % | 2 74% |
| La Entrada | 52 356 | 35 589 | 16 767 | 16 27% | 1 78% | 0 84% | 1 37% | 0 43% | 147 11% | 0 63 % |
| Santa Barbara | 43,125 | 35 373 | 7 752 | 13 40% | 1 46% | 0 69% | 1 36% | 0 43% | 121 92% | 0 52 % |
| TOTAL REGION | 321 777 | 302 403 | 19 374 | 100 00% | 10 91% | 5 15% | 11 66% | 3 66% | 106 41% | 3 89% |
| REGION VI | | | | | | | | | | |
| Juticalpa | 115 924 | 82,008 | 33,916 | 100 00% | 3 93% | 1 86% | 3 16% | 0 99% | 141 36% | 1 40% |
| TOTAL CLINICS | 2 949 057 | 2 592 637 | 356 420 | 100 00% | 100% | 47 22% | 100 00% | 31 37% | 113 75% | 35 68% |
| COMMUNITY SERVICES | | | | | | | | | | |
| REGION I | 240 186 | 265 855 | (25 669) | 18 47% | 18 47% | 3 85% | 27 38% | 3 22 % | 90 34% | 2 91 % |
| REGION II | 356 884 | 240 951 | 115 933 | 27 45% | 27 45% | 5 71% | 24 82% | 2 92% | 148 11% | 4 32% |
| REGION III | 96 180 | 77 307 | 18 873 | 7 40% | 7 40% | 1 54% | 7 96% | 0 94% | 124 41% | 1 16% |
| REGION IV | 336 037 | 182 713 | 153 324 | 25 85% | 25 85% | 5 38% | 18 82% | 2 21% | 183 92% | 4 07% |
| REGION V | 185 193 | 143 631 | 41 562 | 14 24% | 14 24% | 2 97% | 14 79% | 1 74% | 128 94% | 2 24% |
| REGION VI | 85,676 | 60,382 | 25 294 | 6 59% | 6 59% | 1 37% | 6 22% | 0 73% | 141 89% | 1 04% |
| TOTAL PROGRAM | 1 300,156 | 970,839 | 329 317 | 100 00% | 100 00% | 20 82% | 100 00% | 11 75% | 133 92% | 15 73% |
| SOCIAL MARKETING | | | | | | | | | | |
| CENTRAL ADMINISTRATION | 1,577,223 | 866,775 | 710,448 | 100 00% | 100 00% | 25 25% | 100 00 % | 10 49 % | 181 96 % | 19 08% |
| TOTAL | 1 577 223 | 866 775 | 710 448 | 100 00% | 100 00% | 25 25% | 100 00% | 10 49% | 181 96% | 19 08% |
| TOTAL SERVICE PROGRAMS | 5 826 436 | 4 430 251 | 1 396 185 | 100 00% | 100 00% | 93 28% | 100 00% | 53 61% | 131 51% | 70 50% |

| SUMMARY SERVICE PROGRAMS<br>PROGRAMS CLINICS AND REGIONS | INCOME | EXPENSES AND DIRECT COSTS | PROFIT/ (LOSS) | PERCENT DISTRIBUTION BY REGION | PERCENT DISTRIBUTION BY GROUP | PERCENT DISTRIBUTION OF INCOME | PERCENT DISTRIBUTION OF COSTS | PERCENT DISTRIBUTION OF COSTS | PERCENT SELF FINANCING | PERCENT DISTRIBUTION SELF FINANCING |
|---|---|---|---|---|---|---|---|---|---|---|
| REGION III | 316 509 | 275 962 | 40 547 | 18 60% | 18 60% | 5 07% | 20 28% | 3 34% | 114 69% | 3 83% |
| REGION IV | 676 629 | 496 553 | 180 076 | 39 76% | 39 76% | 10 83% | 36 49% | 6 01% | 136 27% | 8 19% |
| REGION V | 506 970 | 446 034 | 60 936 | 29 79% | 29 79% | 8 12% | 32 77% | 5 40% | 113 66% | 6 13% |
| REGION VI | 201,600 | 142 390 | 59 210 | 11 85% | 11 85% | 3 23% | 10 46% | 1 72% | 141 58% | 2 44% |
| TOTAL SERVICE PROGRAMS | 1 701 708 | 1 360 939 | 340 769 | 100 00% | 100 00% | 27 24% | 100 00% | 16 47% | 125 04% | 20 59% |
| SUPPORT PROGRAMS | | | | | | | | | | |
| CENTRAL ADMINISTRATION | 22 276 | 990 915 | (968 639) | 100 00% | 27 52% | 0 36% | 100 00% | 11 99% | 2 25% | 0 27% |
| REGION I | | | | | | | | | | |
| Tegucigalpa | 51 506 | 287 329 | (235 823) | 100 00% | 63 63% | 0 82% | 16 61% | 3 48% | 17 93% | 0 62% |
| Danli | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| Comayagua | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 51 506 | 287 329 | (235 823) | 100 00% | 63 63% | 0 82% | 16 61% | 3 48% | 17 93% | 0 62% |
| REGION II | | | | | | | | | | 0 00% |
| San Pedro Sula | 1 049 | 183 817 | (182 768) | 100 00% | 1 30% | 0 02% | 10 62% | 2 22% | 0 57% | 0 01% |
| Puerto Cortes | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| El Progreso | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 1 049 | 183 817 | (182 768) | 100 00% | 1 30% | 0 02% | 10 62% | 2 22% | 0 57% | 0 01% |
| REGION III | | | | | | | | | | |
| Choluteca | 3 450 | 55 869 | (52,419) | 100 00% | 4 26% | 0 06% | 3 23% | 0 68% | 6 18% | 0 04% |
| TOTAL REGION | 3 450 | 55 869 | (52 419) | 100 00% | 4 26% | 0 06% | 3 23% | 0 68% | 6 18% | 0 04% |
| REGION IV | | | | | | | | | | |
| La Ceiba | 1 240 | 114 456 | (113 216) | 100 00% | 1 53% | 0 02% | 6 62% | 1 38% | 1 08% | 0 02% |
| Tocoa | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 1 240 | 114 456 | (113 216) | 100 00% | 1 53% | 0 02% | 6 62% | 1 38% | 1 08% | 0 02% |
| REGION V | | | | | | | | | | |
| Santa Rosa de Copan | 1 420 | 82 762 | (81 342) | 100 00% | 1 75% | 0 02% | 4 78% | 1 00% | 1 72% | 0 02% |
| La Entrada | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| Santa Barbara | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 1 420 | 82 762 | (81 342) | 100 00% | 1 75% | 0 02% | 4 78% | 1 00% | 1 72% | 0 02% |
| REGION VI | | | | | | | | | | |
| Juticalpa | 0 | 14,992 | (14,992) | 0 00% | 0 00% | 0 00% | 0 87% | 0 18% | 0 00% | 0 00% |
| | | | | | | | | | | 0 00% |
| TOTAL SUPPORT SERVICES | 80 941 | 1 730 140 | (1 649 199) | 100 00% | 100 00% | 1 30% | 100 00% | 20 93% | 4 68% | 0 98% |

| ADMINISTRACION<br>PROGRAMS CLINICS AND REGIONS | INCOME | EXPENSES AND DIRECT COSTS | PROFIT/ (LOSS) | PERCENT DISTRIBUTION BY REGION | PERCENT DISTRIBUTION BY GROUP | PERCENT DISTRIBUTION OF INCOME | PERCENT DISTRIBUTION OF COSTS | PERCENT DISTRIBUTION OF COSTS | PERCENT SELF FINANCING | PERCENT DISTRIBUTION SELF FINANCING |
|---|---|---|---|---|---|---|---|---|---|---|
| CENTRAL ADMINISTRATION | 320 516 | 1 415 127 | (1 094 611) | 100 00% | 94 67% | 5 13% | 67 26% | 17 12% | 22 65% | 3 88% |
| REGION I | | | | | | | | | | |
| Tegucigalpa | 0 | 63 870 | (63 870) | 0 00% | 0 00% | 0 00% | 3 04% | 0 77% | 0 00% | 0 00% |
| Danli | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| Comayagua | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 0 | 63 870 | (63 870) | 0 00% | 0 00% | 0 00% | 3 04% | 0 77% | 0 00 % | 0 00% |
| REGION II | | | | | | | | | | |
| San Pedro Sula | 12 269 | 240 027 | (227 758) | 100 00% | 3 62% | 0 20 % | 11 41% | 2 90 % | 5 11% | 0 15% |
| Puerto Cortes | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00 % | | 0 00% |
| El Progreso | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 12 269 | 240 027 | (227 758) | 100 00% | 3 62% | 0 20% | 11 41% | 2 90% | 5 11% | 0 15% |
| REGION III | | | | | 0 00% | | | | | |
| Choluteca | 2,579 | 111 966 | (109 387) | 100 00% | 0 76% | 0 04% | 5 32% | 1 35% | 2 30% | 0 03% |
| REGION IV | | | | | | | | | | |
| La Ceiba | 33 | 118 603 | (118 570) | 100 00% | 0 01% | 0 00% | 5 64% | 1 44% | 0 03% | 0 00% |
| Tocoa | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 33 | 118 603 | (118 570) | 100 00% | 0 01% | 0 00% | 5 64% | 1 44% | 0 03% | 0 00% |
| REGION V | | | | | | | | | | |
| Santa Rosa de Copan | 893 | 101 041 | (100 148) | 100 00% | 0 26% | 0 01% | 4 80% | 1 22 % | 0 88% | 0 01% |
| La Entrada | 0 | 0 | 0 | 0 00 % | 0 00 % | 0 00% | 0 00% | 0 00 % | | 0 00% |
| Santa Barbara | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 893 | 101 041 | (100 148) | 100 00% | 0 26% | 0 01% | 4 80% | 1 22% | 0 88% | 0 01% |
| REGION VI | | | | | | | | | | |
| Juticalpa | 2 283 | 53 348 | (51,065) | 100 00% | 0 67% | 0 04% | 2 54% | 0 65% | 4 28% | 0 03% |
| | | | | | | 0 00% | 0 00% | 0 00% | | |
| TOTAL | 338 573 | 2 103 982 | (1 765 409) | 100 00% | 100 00% | 5 42% | 100 00% | 25 46% | 16 09% | 4 10% |

SUMMARY SUPPORT AND ADMINISTRATION

| PROGRAMS CLINICS AND REGIONS | INCOME | EXPENSES AND DIRECT COSTS | PROFIT/ (LOSS) | PERCENT DISTRIBU TION BY REGION | PERCENT DISTRIBU TION BY GROUP | PERCENT DISTRIBU TION OF INCOME | PERCENT DISTRIBU TION OF COSTS | PERCENT DISTRIBU TION OF COSTS | PERCENT SELF FINANCING | PERCENT DISTRIBU TION SELF FINANCING |
|---|---|---|---|---|---|---|---|---|---|---|
| CENTRAL ADMINISTRATION | 342 792 | 2 406 042 | (2 083 250) | 100 00% | 81 71% | 5 49% | 62 75% | 29 11% | 14 25% | 4 15% |
| REGION I | | | | | | | | | | |
| Tegucigalpa | 51 506 | 351 199 | (299 693) | 100 00% | 12 28% | 0 82% | 9 16% | 4 25% | 14 67% | 0 62% |
| Danli | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| Comayagua | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 51 506 | 351 199 | (299 693) | 100 00% | 12 28% | 0 82% | 9 16% | 4 25% | 14 67% | 0 62% |
| REGION II | | | | | | | | | | |
| San Pedro Sula | 13 318 | 423 844 | (410 526) | 100 00% | 3 17% | 0 21% | 11 05% | 5 13% | 3 14% | 0 16% |
| Puerto Cortes | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| El Progreso | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 13 318 | 423 844 | (410 526) | 25 86% | 3 17% | 0 21% | 11 05% | 5 13% | 3 14% | 0 16% |
| REGION III | | | | | | | | | | |
| Choluteca | 6,029 | 167,835 | (161 806) | 100 00% | 1 44% | 0 10% | 4 38% | 2 03% | 3 59% | 0 07% |
| REGION IV | | | | | | | | | | |
| La Ceiba | 1 273 | 233 059 | (231 786) | 100 00% | 0 30% | 0 02% | 6 08% | 2 82% | 0 55% | 0 02% |
| Tocoa | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 1 273 | 233 059 | (231 786) | 100 00% | 0 30% | 0 02% | 6 08% | 2 82% | 0 55% | 0 02% |
| REGION V | | | | | | | | | | |
| Santa Rosa de Copan | 2 313 | 183 803 | (181 490) | 100 00% | 0 55% | 0 04% | 4 79% | 2 22% | 1 26% | 0 03% |
| La Entrada | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| Santa Barbara | 0 | 0 | 0 | 0 00% | 0 00% | 0 00% | 0 00% | 0 00% | | 0 00% |
| TOTAL REGION | 2 313 | 183 803 | (181 490) | 100 00% | 0 55% | 0 04% | 4 79% | 2 22% | 1 26% | 0 03% |
| REGION VI | | | | | | | | | | |
| Juticalpa | 2,283 | 68,340 | (66,057) | 100 00% | 0 54% | 0 04% | 1 78% | 0 83% | 3 34% | 0 03% |
| TOTAL ADMINISTRATION AND SUPPORT | 419 514 | 3 834 122 | (3 414 608) | 100 00% | 100 00% | 6 72% | 100 00% | 46 39% | 10 94% | 5 08% |

| TOTAL PROGRAMS AND REGIONS<br>PROGRAMS CLINICS AND REGIONS | INCOME | EXPENSES AND DIRECT COSTS | PROFIT/ (LOSS) | PERCENT DISTRIBUTION BY REGION | PERCENT DISTRIBUTION BY GROUP | PERCENT DISTRIBUTION OF INCOME | PERCENT DISTRIBUTION OF COSTS | PERCENT DISTRIBUTION OF COSTS | PERCENT SELF FINANCING | PERCENT DISTRIBUTION SELF FINANCING |
|---|---|---|---|---|---|---|---|---|---|---|
| CENTRAL ADMINISTRATION | 1 920 015 | 3 272 817 | (1 352 802) | 100 00% | 100 00% | 30 74% | 100 00% | 39 60% | 58 67% | 23 23% |
| REGION I | | | | | | | | | | |
| Tegucigalpa | 1 140 910 | 1 453 000 | (312 090) | 87 88% | 87 88% | 18 27% | 94 76% | 17 58% | 78 52% | 13 81% |
| Danli | 86 262 | 39 078 | 47 184 | 6 64% | 6 64% | 1 38% | 2 55% | 0 47% | 220 74 % | 1 04% |
| Comayagua | 71,032 | 41,211 | 29,821 | 5 47% | 5 47% | 1 14% | 2 69% | 0 50% | 172 36% | 0 86% |
| TOTAL REGION | 1 298 204 | 1 533 289 | (235 085) | 100 00% | 100 00% | 20 78% | 100 00% | 18 55% | 84 67% | 15 71% |
| REGION II | | | | | | | | | | |
| San Pedro Sula | 1 190 923 | 1 356 674 | (165 751) | 90 62% | 90 62% | 19 07% | 93 93% | 16 42% | 87 78% | 14 41% |
| Puerto Cortes | 57 290 | 36 539 | 20 751 | 4 36% | 4 36% | 0 92% | 2 53% | 0 44% | 156 79 % | 0 69% |
| El Progreso | 65 912 | 51,078 | 14 834 | 5 02% | 5 02% | 1 06% | 3 54% | 0 62 % | 129 04% | 0 80% |
| TOTAL REGION | 1 314 125 | 1 444 291 | (130 166) | 100 00% | 100 00% | 21 04% | 100 00% | 17 48% | 90 99% | 15 90% |
| REGION III | | | | | | | | | | |
| Choluteca | 322,538 | 443,797 | (121,259) | 100 00% | 100 00% | 5 16% | 100 00% | 5 37% | 72 68% | 3 90% |
| REGION IV | | | | | | | | | | |
| La Ceiba | 616 855 | 683 917 | (67 062) | 90 99% | 90 99% | 9 88% | 93 74% | 8 28% | 90 19% | 7 46% |
| Tocoa | 61,047 | 45,695 | 15,352 | 9 01% | 9 01% | 0 98% | 6 26% | 0 55% | 133 60% | 0 74% |
| TOTAL REGION | 677 902 | 729 612 | (51 710) | 100 00% | 100 00% | 10 85% | 100 00% | 8 83% | 92 91% | 8 20% |
| REGION V | | | | | | | | | | |
| Santa Rosa de Copan | 413 802 | 558 875 | (145 073) | 81 25% | 81 25% | 6 63% | 88 73% | 6 76% | 74 04% | 5 01% |
| La Entrada | 52 356 | 35 589 | 16 767 | 10 28% | 10 28% | 0 84% | 5 65% | 0 43% | 147 11% | 0 63% |
| Santa Barbara | 43,125 | 35,373 | 7,752 | 8 47% | 8 47% | 0 69% | 5 62% | 0 43% | 121 92% | 0 52% |
| TOTAL REGION | 509 283 | 629 837 | (120 554) | 100 00% | 100 00% | 8 15% | 100 00% | 7 62% | 80 86% | 6 16% |
| REGION VI | | | | | | | | | | |
| Juticalpa | 203,883 | 210,730 | (6 847) | 100 00% | 100 00% | 3 26% | 100 00% | 2 55% | 96 75 / | 2 47% |
| TOTAL | 6 245 950 | 8 264 373 | (2 018 423) | 100 00% | 100 00% | 100 00% | 100 00% | 100 00% | 75 58% | 75 58% |

D-5 Income and Costs by Family Planning and Diversified Service Strategies, First Quarters 1997 and 1998

| STRATEGIES | 1st Quarter 1997 Income | Expenses | Profit/(Loss) | Self-financing | 1st Quarter 1998 Income | Expenses | Profit/(Loss) | Self-financing |
|---|---|---|---|---|---|---|---|---|
| **FAMILY PLANNING** | | | | | | | | |
| Surgery | 249,356 | 312 204 | (62 848) | 79 9% | 308 753 | 549 714 | (240 961) | 56 2% |
| Permanent Method Consultations | 28 675 | 8 810 | 19 865 | 325 5% | 29,812 | 165 749 | (135 937) | 18 0% |
| Temporary Method Consultations | 232,077 | 6 900 | 225 177 | 3363 4% | 391 057 | - | 391 057 | #DIV/0! |
| Community Services Program | 1 356 558 | 819 215 | 537,343 | 165 6% | 1 300 156 | 1 038 986 | 261 170 | 125 1% |
| Social Marketing Program | 332 932 | 253 144 | 79 788 | 131 5% | 1 577 223 | 866 775 | 710 448 | 182 0% |
| Contraceptive Sales | 141 428 | 30 721 | 110 707 | 460 4% | 151 534 | 46 172 | 105 362 | 328 2% |
| TOTAL | 2 341 026 | 1 430 994 | 910 032 | 163 6% | 3 758,535 | 2 667 396 | 1 091 139 | 140 9% |
| **DIVERSIFIED SERVICES** | | | | | | | | |
| Surgery | 46 441 | 1 000 | 45 441 | 4644 1% | 39 299 | 6 918 | 32 381 | 568 1% |
| Consultations | 313 244 | 62,490 | 250 754 | 501 3% | 660 928 | 442 443 | 218 485 | 149 4% |
| Sales of Medicines | 279 392 | 125 550 | 153 842 | 222 5% | 485 003 | 304 554 | 180 449 | 159 3% |
| Cytology Examinations | 502 299 | 107,203 | 395 096 | 468 5% | 633 184 | 193 230 | 439 954 | 327 7% |
| Other Clinic Laboratory Examinations | 164 010 | 52,492 | 111 518 | 312 4% | 234,000 | 95 226 | 138 774 | 245 7% |
| Sales of Other Products | 1,309 | - | 1 309 | #DIV/0! | 4 008 | - | 4 008 | #DIV/0! |
| TOTAL | 1 306 695 | 348,735 | 957 960 | 374 7% | 2 056 422 | 1 042 371 | 1 014 051 | 197 3% |

D-6 ASHONPLAFA Services by Region

| Type of Structure | Regions | | | | | | |
|---|---|---|---|---|---|---|---|
| | I | II | III | IV | V | VI | Total |
| Regional Centers | 1 | 1 | 1 | 1 | 1 | 1 | 6 |
| Surgical Units | 1 | 1 | 1 | 1 | 1 | | 5 |
| Gynecology Clinics | 1 | 1 | 1 | 1 | 1 | | 5 |
| Family Clinics | 3 | 1 | 1 | 1 | 2 | 1 | 9 |
| Laboratory Clinics | 1 | 1 | | | | | 2 |
| Laboratory Cytologies | 1 | 1 | | | | | 2 |
| Coloscopy | 1 | 1 | 1 | 1 | 1 | | 5 |
| Ultrasound | 1 | 1 | 1 | | | | 3 |
| Criosurgery | 1 | 1 | 1 | 1 | 1 | | 5 |
| Electracauterization | 1 | 1 | 1 | 1 | 1 | 1 | 6 |
| Family Planning Posts | 380 | 383 | 181 | 317 | 258 | 137 | 1656 |
| Social Marketing Posts (Pharmacies) | 200 | 120 | 25 | 35 | 6 | 22 | 408 |
| Public Libraries | 1 | 1 | | | | | 2 |
| Family Planning Clinics | 3 | 3 | 1 | 2 | 3 | 1 | 13 |
| Dentistry Clinics | 1 | 1 | | | | | 2 |
| Pediatric Clinics | 1 | 1 | | | | | 2 |
| Laparoscopy | 1 | 1 | 1 | 1 | 1 | | 5 |
| Private Clinics | 3 | 1 | | 2 | 1 | | 7 |

D-7 ASHONPLAFA CYP Achievement by Program and Clinic, First Quarters, 1997 and 1998

| Clinic | Medical/ Clinic Services | Community Services | Social Marketing | 1st Qtr 1998 | 1st Qtr 1997 | Absolute Difference | Percent Difference |
|---|---|---|---|---|---|---|---|
| Tegucigalpa | 5 154 | 2 595 | 10 052 | 17 801 | 9 065 | 8 736 | 96% |
| Danli | 300 | | | 300 | 268 | 32 | 12% |
| Comayagua | 250 | | | 250 | 179 | 71 | 40% |
| San Pedro Sula | 5 831 | 2 278 | | 8 109 | 6 661 | 1 448 | 22% |
| Puerto Cortes | 162 | | | 162 | 160 | 2 | 1% |
| Progreso | 163 | | | 163 | 145 | 18 | 12% |
| Choluteca | 1 265 | 768 | | 2 033 | 2 089 | (56) | -3% |
| La Ceiba | 1 631 | 1 790 | | 3 421 | 3 077 | 344 | 11% |
| Tocoa | 177 | | | 177 | 212 | (35) | -17% |
| Santa Rosa de Copan | 981 | 1 031 | | 2 012 | 2 290 | (278) | -12% |
| Santa Barbara | 280 | | | 280 | 153 | 127 | 83% |
| La Entrada | 122 | | | 122 | 60 | 62 | 103% |
| Juticalpa | 527 | 590 | | 1 117 | 764 | 353 | 46% |
| Private Clinics | 6 950 | | | 6 950 | 5 210 | 1 740 | 33% |
| Total | 23 793 | 9 052 | 10 052 | 42 897 | 30 333 | 12 564 | 41% |

D-8 ASHONPLAFA CYP Achievement First Quarter 1998

| Programs | Annual Goal 1998 | 1st Quarter Goal | 1st Quarter Achieve-ment | Percent of 1st Qtr Goal | Goal Next Quarter |
|---|---|---|---|---|---|
| Medical/Clinical | 129 374 | 32 340 | 23 793 | 73 6% | 41 162 |
| CYP, Tubectomy | 95 050 | 23 763 | 16 310 | 68 6% | 31 216 |
| CYP Vasectomy | 1 160 | 290 | 250 | 86 2% | 330 |
| CYP, Condom | 85 | 21 | 41 | 195 2% | 21 |
| CYP, IUD | 32 778 | 8 194 | 6 867 | 83 8% | 9 523 |
| CYP, Oral | 286 | 72 | 230 | 319 4% | 72 |
| CYP, Vaginal | 15 | - | - | | - |
| CYP, Injections | | | 95 | | |
| | | | | | |
| Community Services | 50 695 | 8 423 | 9 052 | 107 5% | 8 423 |
| CYP, Orals | 46 052 | 7 675 | 8 054 | 104 9% | 7 675 |
| CYP, Condoms | 4 490 | 748 | 812 | 108 6% | 748 |
| CYP, Vaginal | 153 | - | - | | - |
| CYP, IUD | - | - | 186 | | - |
| | | | | | |
| Social Marketing | 27 426 | 6 857 | 10 052 | 146 6% | 6 857 |
| CYP, Orals | 20 006 | 5 002 | 7 240 | 144 7% | 5 002 |
| CYP, Condoms | 7 420 | 1 855 | 2 812 | 151 6% | 1 855 |
| Total | 207 495 | 47 620 | 42 897 | 90 1% | 56 442 |

Note There are no goals for vaginal contraceptives (nor for injectables)

D-9 ASHONPLAFA Service Achievement (in units), First Quarter 1998

| Programs | Annual Goal 1998 | 1st Quarter Goal | 1st Quarter Achieve-ment | Percent of 1st Qtr Goal | Goal Next Quarter |
|---|---|---|---|---|---|
| Medical/Clinical | | | | | |
| Sterilizations | 9 621 | 2 405 | 1 656 | 68 9% | 3 154 |
| Female | 9 605 | 2 376 | 1 631 | 68 6% | 3 121 |
| Male | 116 | 29 | 25 | 86 2% | 33 |
| | | | | | |
| IUD Insertions | 9 365 | 2 341 | 1 765 | 75 4% | 2 917 |
| IUD Revisits | 30 951 | 7 738 | 5 392 | 69 7% | 10 084 |
| | | | | | |
| Diversified Services | 53 949 | 13 487 | 8 132 | 60 3% | 18 842 |
| | | | | | |
| Laboratory Exams | | | | | |
| Cytologies | 56 189 | 14 047 | 14 334 | 12 0% | 14 047 |
| Clinical Laboratory | 21 706 | 5 427 | 4 488 | 82 7% | 6 366 |
| | | | | | |
| Other Activities | | | | | |
| Diagnostic Laporascope | 336 | 84 | 23 | 27 4% | 145 |
| Coloscopy | 460 | 115 | 127 | 110 4% | 115 |
| Ultrasound | 1 248 | 312 | 202 | 64 7% | 422 |
| Cnotherapy | 143 | 36 | 11 | 30 6% | 61 |
| Biopsies | 90 | 23 | 49 | 213 0% | 23 |
| Cauterizations | 100 | 25 | 55 | 220 0% | 25 |
| | | | | | |
| Clinic Sales | | | | | |
| Orals | 4 288 | 1 072 | 3 452 | 322 1% | 1 072 |
| IUDs | 9 365 | 2 341 | 1 962 | 83 8% | 2 720 |
| Condoms | 10 189 | 2 547 | 4 905 | 192 6% | 2 547 |
| Vaginals | 87 | - | - | | - |
| Injections | - | - | 380 | | - |
| | | | | | |
| Community Services | | | | | |
| Orals | 690 787 | 115 131 | 120 802 | 104 9% | 115 131 |
| Condoms | 538 860 | 89 810 | 97 432 | 108 5% | 89 810 |
| Vaginals | 918 | - | - | | - |
| IUDs | | | 53 | | |
| FP Posts | | | 1 639 | | |
| | | | | | |
| Social Marketing | | | | | |
| Piel | 140 200 | 35 050 | - | 0 0% | 70 100 |
| Duofen | 300 096 | 75 024 | 108 600 | 144 8% | 75 024 |
| Norminest | | | | | |
| Perla | | | | | |
| Guardian | 750 200 | 187 550 | 337 536 | 180 0% | 187 550 |

Note There are no goals or vaginal contraceptives (nor for injectables)